- *Hospital Planning Portfolio*
- *Book On Baby Care for Maternity Patients*
- *Mental and Emotional Problems of Anesthesia*

March
VOLUME 70
NUMBER 3
1948

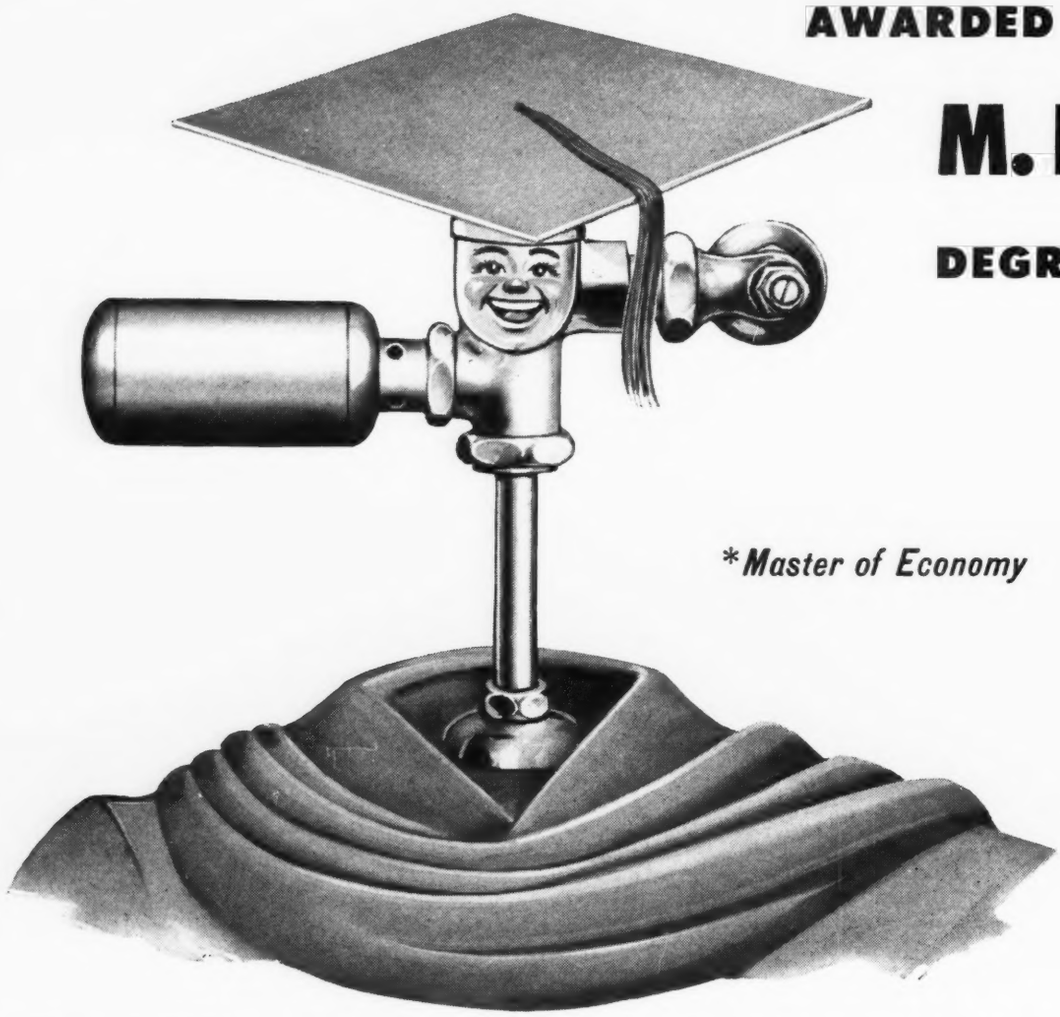
the Modern Hospital

Sloan *Electrically Operated* Flush Valve

AWARDED

M. E.*

DEGREE



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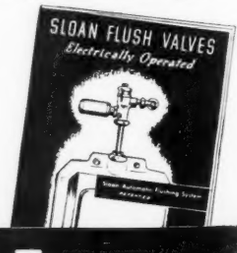

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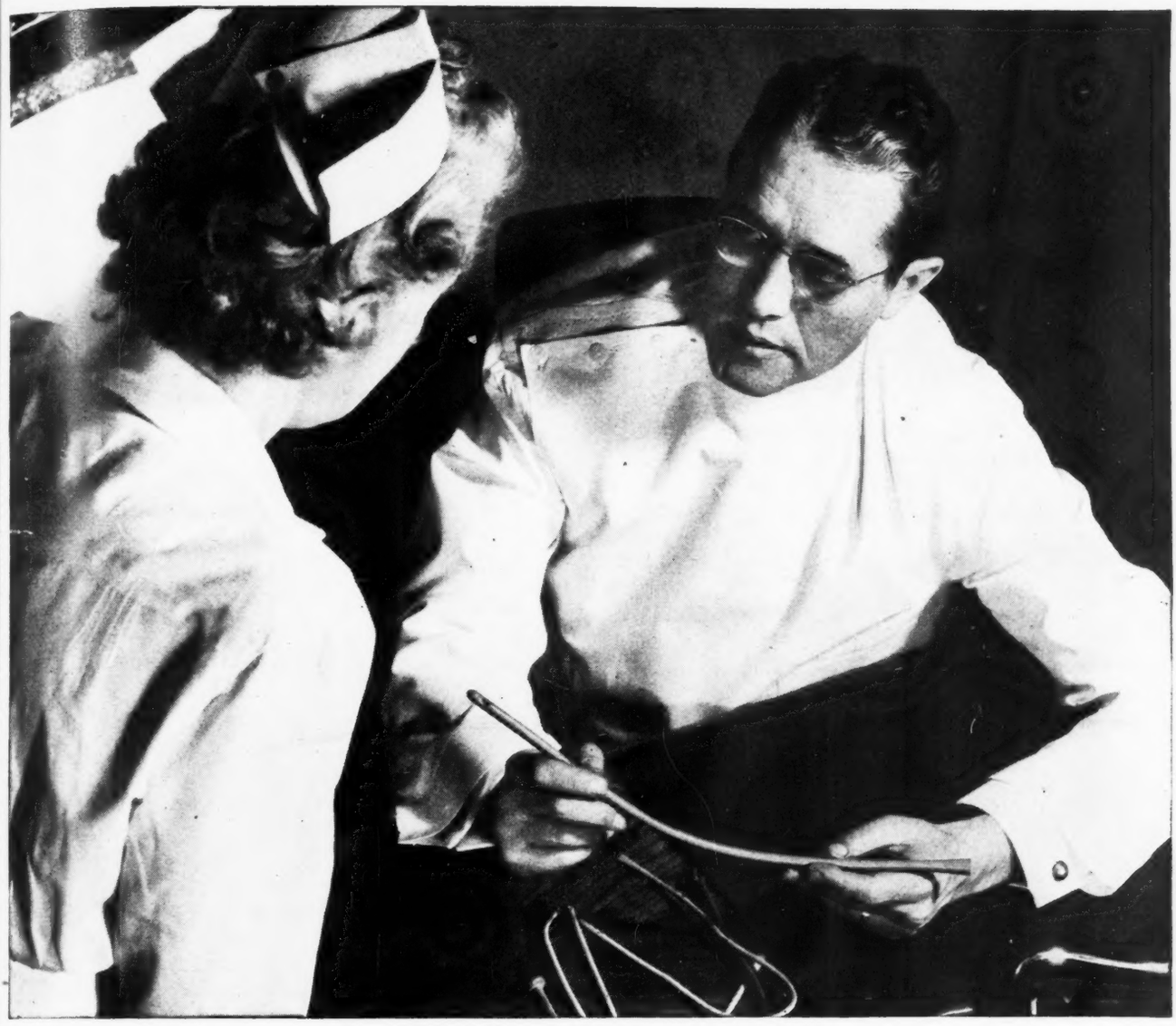

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Accelerated laboratory tests and hospital sterilization practices reveal a remarkable ability to withstand repeated sterilization — more than any prewar surgical tube.

They are members of a family of 37 dependable rubber products for hospital and home use, which includes: Pezzar, Coude, Malecot, Robinson and Whistle Tip Catheters; intravenous tubing, surgeons' gloves, water bottles, rectal syringes, invalid rings, ice caps, drainage tubing, breast pumps, Koroseal film and sheeting. All available through your hospital supply house or surgical dealer. *The B.F.Goodrich Co., Sundries Division, Akron, Ohio.*

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Administration

Trustee Forum

Medicine and Pharmacy

Food and Food Service

Maintenance and Operation

Regular Features

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AMONG THE AUTHORS

N. A. Owings

Nathaniel A. Owings is a member of the architectural firm of Skidmore, Owings and Merrill of Chicago, New York and San Francisco, and chairman of the Chicago Plan Commission, a position to which he was appointed by the mayor two months ago. In addition to numerous hospitals and other public buildings, Mr. Owings has designed apartment buildings, college dormitories and whole communities. For example, he was one of the architects who laid out the town of Oak Ridge, Tenn., which became a city of 75,000, and he is presently building a city for 30,000 oil company workers in Venezuela. He is also a member of the architectural group that is designing a permanent home for the United Nations in New York City. Following his graduation from Cornell University School of Architecture in 1927, Mr. Owings, who is now 45 years old, studied building design in Japan, China, India and Egypt. He returned home and became supervising architect for the Century of Progress exposition in Chicago in the early thirties.

Mari Hirons

Mari Hirons is editor of *An Ounce of Prevention,* the lively health education bulletin published monthly by the voluntary health agencies of Lake county, Indiana. Before she started the *Ounce* two years ago, Mrs. Hirons was a member of the staff of the Commission on Hospital Care in Chicago, where she edited the monthly report issued by the commission during its study of hospital facilities and needs throughout the country. A graduate of the University of Indiana's school of journalism, Mrs. Hirons first went to work as an editorial assistant on *Hygeia,* health magazine of the American Medical Association. Later, she did health education work for the Michigan State Health Department at Lansing. The ideas developed in her article on page 73 originated at the time she had her first baby, a little over a year ago.

F. R. Veeder

Fredric R. Veeder is administrative assistant to Director Frank Bradley of Barnes Hospital, St. Louis, where he served an administrative internship following graduation from the University of Chicago course in hospital administration. Mr. Veeder is also assistant in the hospital administration course offered at the Washington University School of Medicine. A graduate of the University of Montana, Mr. Veeder took his master's degree at the University of Chicago in 1938. He was director of public assistance for the state of Montana for four years, then became executive director of Montana Blue Cross, a position he held until he went into the U. S. Marine Corps in 1942.

Carol Cooley

Carol H. Cooley is director of social service at Presbyterian Hospital, Chicago, a position she has held for four years. A graduate of the school of social service administration at the University of Chicago, Mrs. Cooley has done social service work at both public and private hospitals, and for public welfare agencies. She has served as treasurer of the American Association of Medical Social Workers.

Roving Reporter

Practical Nurse Training

Other cities and states will want to know about the practical nurses being trained by the public school system of Seattle, as a part of an adult education program. For six years the Broadway-Edison Technical School in Seattle has trained women as practical nurses and last year the program was accredited by the Washington State League of Nursing Education.

The course covers 540 hours of classroom work, after which the women enter cooperative hospitals in the city for five months of practical training. After they have completed both school and practical training, they get jobs in hospitals under professional nurses or work in homes under a doctor's direction.

A new class started at the end of January. Lillian K. Hocking, coordinator of women's occupations, Broadway-Edison Technical School, Seattle, can furnish further information. She has had letters from thirty states in the last year asking for information about the course.

Dogs for Research

Atlanta, Chicago, Dallas, Detroit, Houston and St. Louis are the six American cities that, by means of local ordinance, are permitted to supply dogs from the city pound to medical schools and hospitals for research purposes. Several other cities authorize delivery of stray animals to medical institutions, though not specifically by ordinance.

The National Society for Medical Research has recently completed a survey of how medical institutions get dogs for their training and research programs. Sixty-four schools in forty-six cities replied to a questionnaire and most of them were dissatisfied with methods they had to use to get dogs for experimental purposes.

The fifteen institutions that get their dogs exclusively from the city pound are well enough satisfied but many others have to get some or all of their dogs from dealers or from individuals functioning as dealers at exorbitant prices. They complain also of erratic delivery, poor selection and poor condition of the animals when obtained from private sources. All of these factors hamper medical research.

Says the National Society for Medical Research in reporting on its survey: "Many respondents were struck by the injustice of their position. They felt that medical schools were entitled to receive animals from the city pound since they were needed for work that would benefit the community and since the animals were otherwise destroyed (not always legally and not always mercifully) instead of being used to advance medical knowledge."

On the bright side of the picture was the instance of one local humane society that delivers dogs from the pound to the medical school in a specially built truck under the care of uniformed officers. The officers inspect the animal quarters on each visit and the governing officers of the society make inspections when they wish.

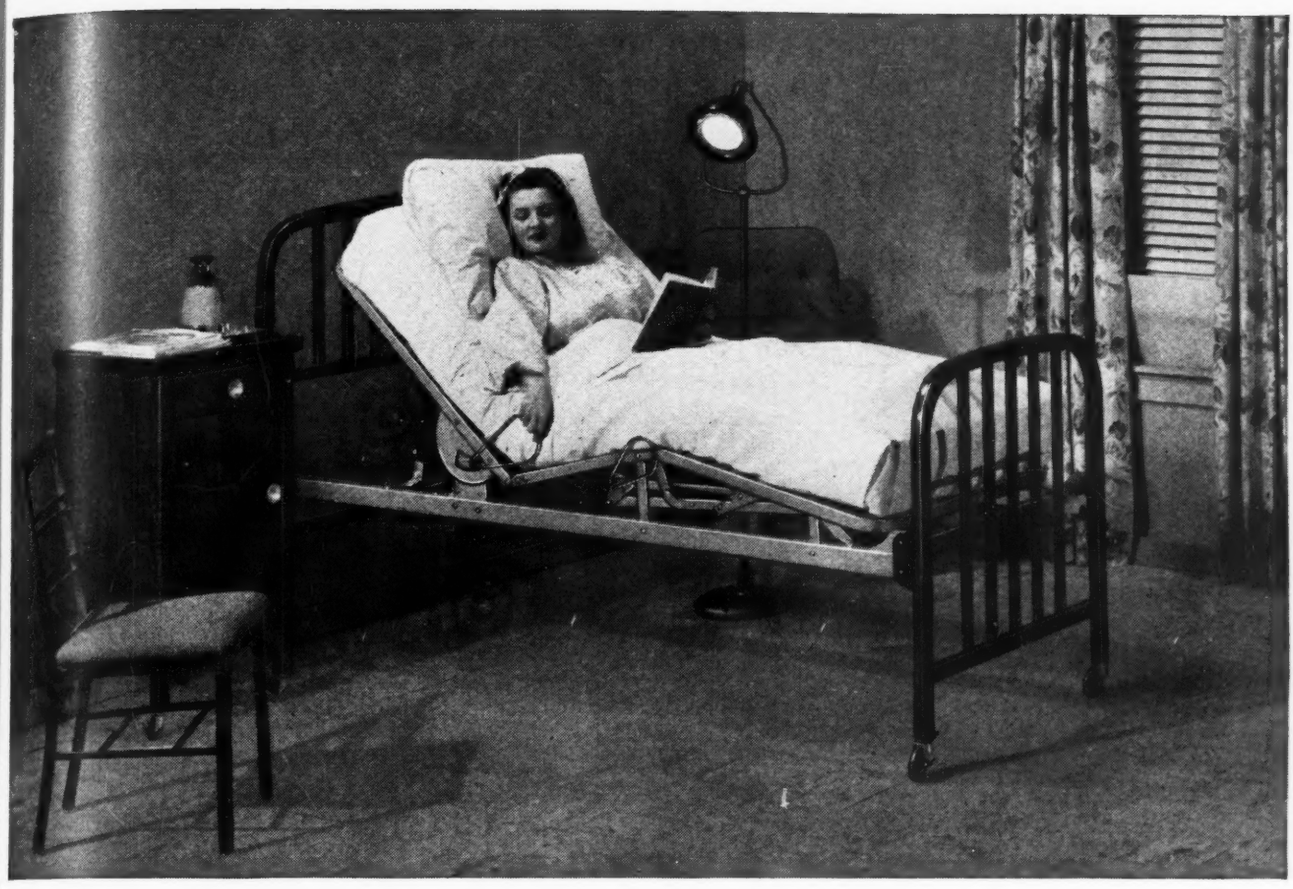
How to Get a Hospital

"Everybody is talking about hospitals. Is anybody *doing* anything about hospitals?"

In Alabama, the extension service of Alabama Polytechnic Institute and the state department of public health have joined hands in preparing "So You Want a Hospital," a fact sheet for community leaders.

This booklet tells what a hospital building costs, how it can be paid for, why communities should not wait to build needed facilities until prices go down, how to form a county hospital association, who starts the ball rolling, what people should be sounded out first, how to organize a study group, and where to go from there.

The eight page pamphlet concludes its simple vigorous message with the statement that Alabama *can* afford good hospital. For what Alabamians spend in one year on liquor and tobacco every man, woman and child in the state can have complete hospital facilities.



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A Layman Suggests—

During the war servicemen wore "dog tags" stamped with their names and a short medical history. A Chicago citizen, W. H. Walworth of 618 Fullerton Parkway, would like this identification system adapted to civilian use since more people are killed or wounded in automobile accidents than are killed or wounded during war.

Mr. Walworth contends that the carrying of a red identification card would speed the transportation of accident victims to the hospital and would prevent the present evil of holding accident patients in the emergency room until the hospital can determine whether they are pay or clinic patients. In fact, he would have a financial rating on the identification card roughly to show the economic status of the bearer.

An adult would carry this red identification card in bill fold or purse, and a child would wear a cheap silver or gold bracelet of the split clamp type with his name, street number and telephone number stamped or engraved on it.

Both sides of the card Mr. Walworth proposes are shown.

ACCIDENT CARD

Name .....
Fee will be paid to anyone responsible for transportation of any kind
To ..... or any Hospital
Address ..... of Hospital
Notify .....
Address .....
Phone: Home ..... Office .....
Hospital Information—OVER

INSURANCE Blue Cross ☐ Solvent ☐ Other ☐ Clinic ☐
Blood Type O ☐ A ☐ B ☐ AB ☐ Rh Pos. ☐ Neg. ☐
Have you ever had Penicillin .....
Heart: Good ☐ Fair ☐ Poor ☐ Unknown ☐
Known Allergies .....
..... Family Doctor

Tip to Movie Magnates

We suggest that MGM buy the movie rights of "The Continuing Story of Manhattan Eye, Ear and Throat Hospital." We don't know when we have read as fascinating, as dramatic or as simply told a story as this one, which turns out to be the hospital's 77th annual report.

Signed by President Stanley Resor, the "Preface for a Layman" is a superb bit of salesmanship. And if the camera shots that illustrate the story are a sample of the drama that takes place in this one hospital, how fascinated the public would be with a full length film of goings-on in such strange spots as the aniseikonia clinic, the facial palsy clinic (where the suddenly grotesque regain "the language of facial expression") and other special clinics. How the public would enjoy peaking over a child's shoulder into the synotophore to see first a cage, then a parrot and then, with only a little training to develop binocular vision, the parrot sitting in the cage!

People would flock to movie houses to see such a film and all hospitals everywhere would gain public admiration and public financial support.

READER OPINION

Job Seeking Ethics

Sirs:

The suggestions made in reference to the manner of gathering information would lead the protégé of Dr. Justice into troubled waters. All of us would be happy should everyone in our community sing our praises. But can even the best of us hope for that? Experienced doctors know only too well that one cannot always judge the reliability, honesty and competency of a physician solely on the popularity he enjoys among his patients. This, no doubt, holds true of hospitals too. Where is the druggist or merchant who would divulge of a customer that he must be bribed? Yet an unscrupulous or disgruntled competitor may readily spread such rumors. Where is the Chamber of Commerce or Community Chest secretary who would dare even to whisper a bad word to a perfect stranger about a home town organization? The trouble is not with the type of information Keene Steele is advised to gather, but in the paucity of sources where he can reliably obtain it.

It is of interest to note that none of the counselors has referred Keene Steele to the one organization which is composed solely of hospital administrators, the American College of Hospital Administrators. And rightly so, because the college has yet to reach the point so long occupied by such outstanding professional organizations as the American Roentgenological Society, the American Association of Clinical Pathologists and the American Association of University Professors in protecting the welfare of their members. Yet the welfare of the hospital administrator is intimately interwoven with the welfare of his institution.

The fledgling administrator should also be advised in time that the "job expectancy" of the average superintendent in a given position is short indeed, and that in time of need he cannot turn for advice or help to his professional organization as, for instance, a college professor can to his.

"Though the American Association of University Professors is organized for many purposes other than making adjustments in conflict situations," says Logan Wilson in the "Academic Man" (Oxford University Press, 1942), "it is the sole available professional agency of this type for most of the groups and hence inevitably finds itself confronted with a large number of such cases. Its codes provide enactment for guidance in such situations, its officers are prepared to act in judiciary capacity, and, in addition, there are sanctions which may be brought to bear upon the offending institution."

How much trouble and unnecessary loss to both administrators and hospitals alike could be prevented, if there existed an unbiased and respected professional organization to which governing boards and administrators could turn for adjustment of their real or fancied grievances, instead of severing connections for lack of a trusted intermediary at the time of a crisis?

The present generation of hospital administrators, through its professional organizations, has provided the young man entering the field with splendid opportunities for his professional preparation to shoulder the tasks ahead. Hasn't the time come to give equal thought to the assurance of the security of his tenure so that he may safely enjoy the fruits of his study to his own professional satisfaction and to the benefit of the institutions he is called to administer?

M. Pollak, M.D.

Peoria, Ill.

Sirs:

Dr. Pollak doubts that drug salesmen or officials of Community Chests and chambers of commerce would give out information about hospitals in their cities. I can assure him, from personal experience, that they will talk freely. All that is necessary is to approach them properly, display some knowledge of institutions and interest in hospitals. No reason exists to make the sort of information that Keene Steele needs either confidential or derogatory. A general appraisal of the position held by the hospital in the opinion of the community is wanted.

Lucius W. Johnson, M.D.

San Diego, Calif.

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

To Bathe or Not to Bathe

Question: Are many hospitals now using the technic which omits the daily bathing of infants in the hospital nursery?—A.M., Calif.

ANSWER: Our nursery routine for the admission and care of the newborn states in part: *"Bath:* No bath is given unless ordered. Inspect all folds and creases; wipe with pledget of dry cotton. Cleanse thighs and buttocks with sterile cottonseed oil each time the diaper is changed (using pledgets of cotton). Do not cleanse any part of baby with water at any time."

Infants who weigh less than 6½ pounds are on a third-hour schedule, those over 6½ pounds are on a fourth-hour schedule. We do not bathe the babies and use oil only on the buttocks. We have found this very satisfactory; it has saved much time in nursing and our results have been good.—MABEL A. BARRON.

ANSWER: We have omitted the daily bathing of our newborn babies for quite a number of years and are extremely well satisfied with the results of this type of care. Following are the procedures used, together with their advantages:

At delivery, the vernix caseosa is not removed, only excessive amounts of blood and mucus being cleaned off with warm water and sterile cotton balls. This eliminates the cooling of the skin and lowering of the temperature which occurs when babies are bathed following delivery.

During the hospitalization period, the baby is not bathed at all. Warm water is used to clean the buttocks following stools. A small amount of mineral oil is used in the creases of the neck, axilla and hands, only when there is an excessive amount of lint, cotton or scaling skin in those areas.

With this technic, skin infections such as impetigo do not develop. Occasionally a baby develops an irritated skin, but there is no infection. Also, the baby's heat mechanism is stabilized sooner, inasmuch as there is no lowering of the body temperature as a result of bathing. Nursing time is reduced to from seven to ten minutes for each baby, including changing the crib.

Parents very readily accept this method of skin care when the purpose of it and its advantages to the infant are explained to them.—CHARLES N. HOLMAN, M.D.

Special Size Unnecessary

Question: We have looked all over the country to find a manufacturer who will cut gauze of a 20 by 24 mesh into two sizes: 18 by 18 and 18 by 12, double fold. So far, we have been out of luck. The companies we have talked to all refuse to have anything to do with it. On the other hand, these same companies will cut to the same size the same type of gauze in a 20 by 12 mesh. I know one of the answers is to buy a gauze-cutting machine, but our small hospital does not like to invest $250 in one of these. At a price differential of 5 cents for cutting the gauze, it would take us twenty years to offset the purchase price of the gauze-cutting machine. It seems to me, with the 20 by 24 mesh gauze costing more than the 20 by 12, the manufacturers should be willing to cut it. Now, I would like you to advise me if you know of any gauze manufacturer who is good natured enough these days to cut gauze to these two sizes to help out a poor, struggling hospital.—W.P.S., Conn.

ANSWER: Why must you have a special size of gauze? The latest revision of the U.S. Bureau of Standards and the American Hospital Association's standards and simplified practice recommendation on gauze would seem to meet the needs of all hospitals. The number of this standard is R86-42. I would urge this hospital to change its procedures so as to use only the standard sizes recommended in this report.

Until hospitals realize the necessity of simplification and standardization, and of conforming with recommendations made by the national association, they will never be able to reduce costs materially.

For Better Attendance

Question: How can attendance at clinico-pathological conferences be encouraged in the small hospital?—M.N., Wash.

ANSWER: The key to a really good clinical pathological conference is, of course, the availability of a competent, courageous, diplomatic pathologist. It is recognized that the average small hospital will not have the full time services of a pathologist. However, we assume that any hospital, worthy of the name, has a contractual arrangement with some pathological laboratories to examine all surgical tissue.

If this is the case, it would seem that arrangements could be made to have a pathologist from the laboratory visit the hospital at least once a month to discuss all death cases and to go over with the surgeons on the staff the results of the pathologist's examination.

Too much stress cannot be placed on the attendance of a pathologist at such a conference if the hospital is to develop high standards of patient care.—EVERETT W. JONES.

Save With Softener

Question: How large must a hospital laundry be to make a water softener an economic asset? What advantages does it afford?—A.H., Ill.

ANSWER: There is no question but what a water softener will pay for the investment in the fifty bed hospital that has a laundry, as well as in the larger hospitals. The investment is in proportion to the size of the equipment necessary to do the job and therefore the savings made will also be in proportion to the initial investment.

In supplies alone that are saved when soft water is used, the investment should pay out in at least two years. Besides this saving, there will be at least 30 or 40 per cent saved in linen replacement. Also, the quality of the linen will be much higher and there will be few, if any, complaints from patients. Washing formulas should be changed for use with soft water and the time necessary to wash will be reduced.

The conclusion is that no matter how small a hospital laundry is a water softener can be an economic asset.—LELAND J. MAMER.

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Looking Forward

Light Up the Truth!

WHETHER the national public relations program for hospitals this year will recruit needed nurses and other workers into hospitals and bring about a happier view of the hospital generally in the community, as it is designed to do, will depend in large measure on how effectively it is followed up by individual hospital efforts. But it will depend on something else, too—something that is frequently overlooked: It will depend on the truth of what is said about hospitals in national and local publicity.

The only proper function of public relations is to light up the truth. Too often, we use our marvelous public relations skills and technics for other purposes. Instead of lighting up the truth, public relations technics are often used to conceal the truth, or to distort the truth, or to present only a particular aspect of the truth that makes somebody look good. This happens right along in government, in business, in labor and in many other phases of our national life. Unquestionably, it has contributed to widespread mistrust of government, and business, and labor.

Hospitals which fail to light up the truth in their public relations will inevitably reap a harvest of public mistrust. To the extent that any public statement made in behalf of hospitals departs from the truth, that statement eventually will hurt hospitals more than it can ever help them. Here is something important to remember in connection with hospital public relations: Practically every person to whom a hospital may address some statement about itself has an actual experience by which he will measure the truth or falsity of the statement.

In this respect the hospital is much more immediately accountable for the truth of its public relations than business is, or labor or government. Very few people have enough experience to know whether a particular thing that is said about business, or unions or government, is true or false. But everybody has been to the hospital—if not as a patient, then at least as a visitor.

So if a hospital public relations program makes some assertion to the effect that everybody in the hospital is dedicated to the service of suffering mankind, say, and this is manifestly untrue in terms of the experience of a reader who has just been shoved around or brushed off by an admitting clerk or cashier, or by an intern or nurse, or if, in the same paper with the hospital's statement, the reader sees a news story which says the nurses are threatening to walk out unless they get higher pay, then he is not going to be impressed by what the hospital says. As a matter of fact, the chances are that he will think even less of the hospital than he did before. In addition to his previous experience with hospitals, he now has an impression of hypocrisy.

This must not happen! The public must not be allowed to develop the skeptical, cynical attitude toward hospitals that some people have today toward business, toward unions and toward government—an attitude which is caused in many cases by the fact that people have been deceived. The business, or the union, or the political body, or the hospital that departs from the truth in its public relations does not necessarily do so with the intent to deceive, to misrepresent or to conceal the truth. On the contrary, it is likely that in all but a few cases these groups are convinced that they are simply expressing the facts in a positive fashion, or putting their best foot forward, or stating the case favorably. Few of them realize that there is a moral point involved when the positive statement, or the best foot, or the favorably stated case falls short of the truth.

Does this mean that to serve the truth hospitals must stop making favorable statements about themselves in their public relations programs?

Of course not, provided they are true statements. It is a fine thing and an intelligent thing to call a

job or a vacancy in the hospital an "opportunity to serve," for example, provided that it is an opportunity to serve and not just a job or a vacancy. The difference is more than one of words alone. There is only one way for the administrator or physician to judge the truth of what is said about his hospital. In the words of St. Augustine, he must "consider within himself whether what has been said has been said truly, looking to that interior truth within the mind informed by God."

When this interior truth in the mind tells him that a job in the hospital is really an opportunity to serve, then he may go forth and call it that and reap the benefits. But when the interior truth informs him that a job in the hospital is ill paid and disorganized and poorly supervised, then he must strive mightily to improve it before he can call it opportunity. The Book of Ecclesiastes in the Old Testament says, "Better it is that thou shouldst not vow, than that thou shouldst vow and not pay." Hospitals can survive every pressure of economic circumstance that these difficult years may produce, but it is doubtful that they can survive if they have to carry the dead weight of unpaid vows. The hospital which claims to be something that it is not has thrown away one precious thing a hospital has always had up to now—its righteousness.

All of us believe deeply in the righteousness of the hospital cause. Whatever the individual motivations of administrators, doctors, nurses and other hospital workers, the purpose of the hospital itself, the whole great, complex organism, is neither gain nor glory. The purpose rather is to serve, and this is a righteous purpose. Righteousness can dwell only where truth is also.

Hospitals, cling to your righteousness! Light up the truth, and you can stand proudly in your communities forever. Depart from truth, lose righteousness, and not all your superb knowledge and skill, nor all your finest public relations technics, can save you. *"I have been young and now am old,"* said David in the Psalm; *"yet have I not seen the righteous forsaken."*

Miracle Is the Word

OLD Doc Brady is at it again. In a recent feature appearing in his syndicated newspaper column, the corny medical codger urged husbands to insist that they be allowed to stay in the delivery room while their wives are having babies. All the health department and hospital regulations painstakingly worked out to protect mothers and babies are brushed aside by Doc as "tricks of the trade designed to keep the riffraff regimented." If the physician raises a question about the husband's right to be in the delivery room or the advisability of his being there, Doc has an easy rule for him to follow: "Find another doctor."

In several cities where the Brady column appears, this article has caused hospitals a certain amount of embarrassment and grief. It may be, however, that Doc has stumbled on something here that will wipe out all his past sins and earn him everlasting fame. Get this: "As long as young expectant fathers remain too weak, delicate or ladylike . . . to share in the greatest thrill a man can experience, the miracle of the birth of his child, hospitals will continue pushing the prospective father around."

Fathers going to share in childbirth? Doc Brady, you should live so long!

Doctor Right Hand, Meet Doctor Left Hand!

ANNOUNCEMENT that the American Medical Association had withdrawn its 700 Chicago headquarters employes from Blue Cross in favor of a commercial insurance company first stunned, then infuriated Blue Cross and hospital people, as well as physicians, all over the country. Within a week after the announcement, a Chicago doctor connected with Blue Cross said he had received angry letters from every state in the Union.

The switch was made only a few weeks after A.M.A. President Bortz appeared at the Blue Cross-Blue Shield commission meeting in Washington and assured the two groups of "every possible assistance." Still more recently, the Chicago Medical Society, after years of study and deliberation, had joined forces with Blue Cross to offer the public a joint hospital and medical service prepayment program. Closely following an announcement of this program, news that the A.M.A. had rejected Blue Cross left the public understandably bewildered.

Explanation of the move by an A.M.A. official was that Blue Cross could not guarantee that its rate would not be increased during the contract year, whereas the insurance company did offer such assurance. It is simply inconceivable that the A.M.A. management, after all these years, does not understand the difference between service and cash benefits—a difference which makes the insurance company's fixed rate guarantee meaningless in terms of real protection in a period of rising hospital costs. Yet the charitable view is that some such misunderstanding did in fact exist.

The only other interpretation possible is that the A.M.A. talks one way and acts another.

HOSPITAL PLANNING

- ROUND TABLE TALK
- CONSTRUCTION COSTS
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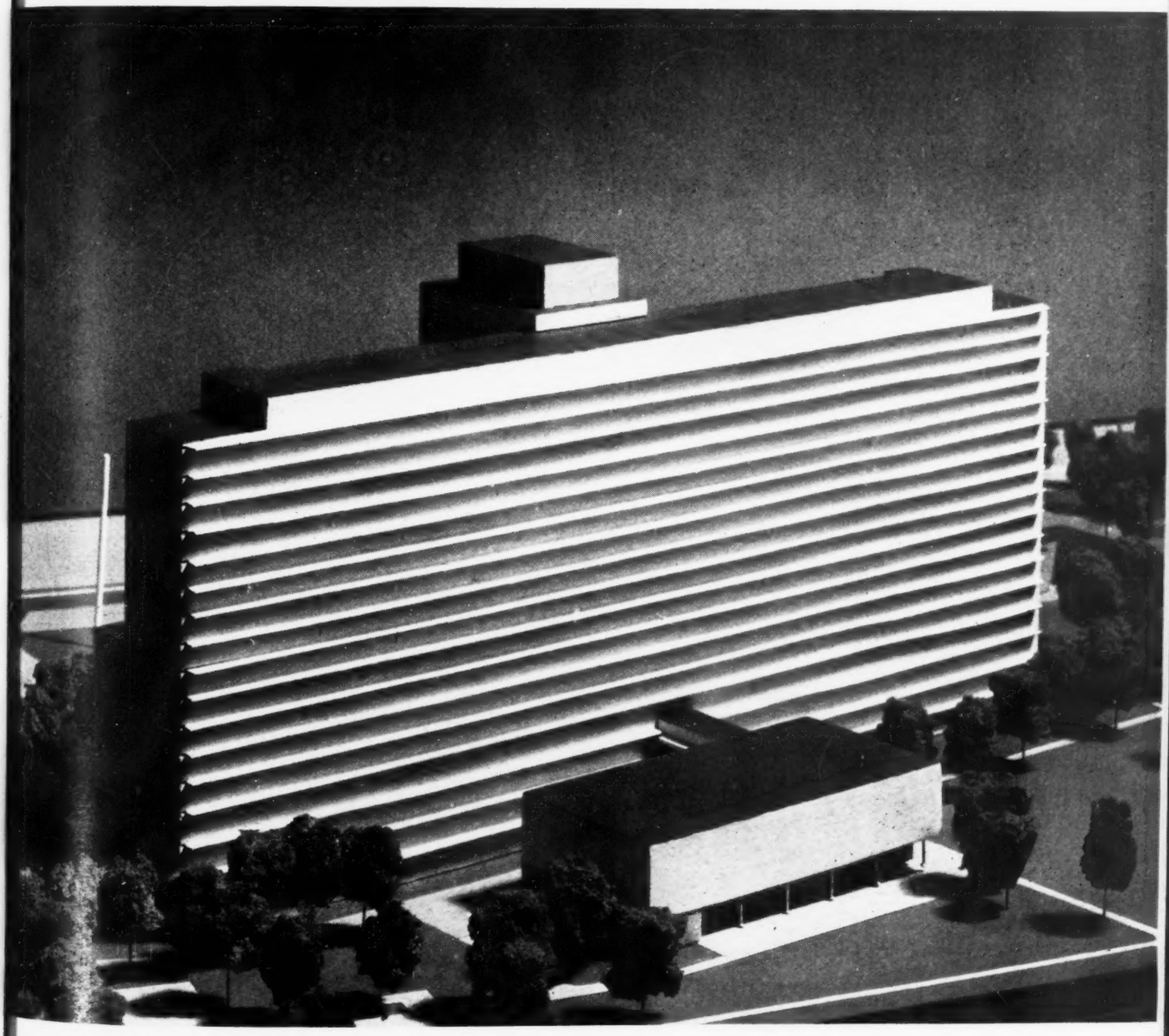


Who Should Take Part in

Planning Our Hospitals?

A MODERN HOSPITAL ROUND TABLE

WITH more than a billion dollars in hospital construction in prospect for the next few years, hospital planning becomes a major social and economic consideration, as well as a technical problem. Good planning now will help doctors, nurses, administrators and others provide good care, in the years to come, without wasting tax or community funds. Bad planning will mean poor care or excessive costs.

To discuss all the aspects and implications of hospital planning today, The MODERN HOSPITAL invited a group of experts to its editorial offices in Chicago a few weeks ago. Taking part in the discussion were: Alfred L. Aydelott of Memphis, Tenn., hospital architect; Herman Smith, M.D., Chicago hospital consultant; Ray Brown, superintendent of the University of Chicago Clinics, and Robert T. Sherman, president of the board of directors of the Evanston Hospital, Evanston, Ill. Everett W. Jones, vice president of The Modern Hospital Publishing Company, was the moderator.

So that all our readers might sit in on the discussion, we had a stenographer in the room taking down all that was said. In the following pages, The MODERN HOSPITAL presents a transcript of the discussion, condensed somewhat to eliminate repetition and duplication.—THE EDITORS.

MR. JONES: The tremendous interest in providing better hospitals underlines the need for free discussion of all the things that have to be done in hospital planning. We hear a great many arguments about the place of the architect, the consultant, the administrator, the building committee of the board, and department heads, and just what part each group should play. Dr. Smith, let's start with a brief expression of your opinion about the job that any group has to do before actual hospital planning begins.

DR. SMITH: All right. They should think first of what they need to do as far as the community is concerned. At the present time, many of these community needs are outlined pretty authoritatively and pretty definitely by the various hospital surveys.

MR. JONES: You mean the surveys under Public Law 725?

DR. SMITH: That's right. However, I think there are individual variations. The official surveys have to be guided by certain set facts, such as number of beds per population unit, and all of us know that some areas, because of economic and other factors, may need a few more beds. Also, the types of services that the various communities need must be considered.

Having determined what these various services are, the community then has to think about how they can meet these needs from the standpoint of manpower. It may be fine to say, "Such and such services are needed in a particular community," but if you don't have the physicians to do those particular jobs, you just can't do them.

Let's assume that you have made this study of your community needs and you have the facts before the board, the medical staff, and other interested persons in the community. From then on, I presume you should blueprint how you want to meet these objectives.

MR. JONES: I'd like to interrupt right there, Dr. Smith. You point out that the state survey will give some idea of what you need in a community. Well, Mr. Brown has had some experience in that. Do you agree that in many cases it might be wise to have your own private consultant for the hospital come in and make a more minute study of the immediate community than might be available under the state plan?

MR. BROWN: I think that is necessary. I don't believe the state plan is worth anything to the individual hospital in attempting to plan its program. There are two things you can use the state plan for: You can use the same standards to measure needs, and you can use the state survey in attempting to find out what you should do in relationship to what

town X in the next county is doing. But I still believe that each hospital should put on its own detailed study, and I believe in the consultant doing that, because he sees factors that the man who is busy running the hospital isn't going to see.

MR. JONES: Anybody else have a thought on that? Have you run into it in your architectural work, Mr. Aydelott? Do you think it might be wise to have a separate, independent consultant make a minute study of the particular hospital area?

MR. AYDELOTT: Absolutely. For the reason that the surgeon general's formula is based on a pretty elevated idea of what is needed. The actual need, the one that is to be met immediately, is much less ambitious, as a rule.

MR. BROWN: Let me point out another thing. Frequently, states think of a project in terms of counties and approach the state survey from the county basis. For example, about thirty out of 100 North Carolina counties have no hospital, so they have said that each county should have a hospital. Yet we know that it is much easier to get from, we shall say, Madison County, into Asheville than it is to get to the county seat. If the greater part of the population is not lined up with the county seat, the state survey figures won't always hold.

MR. JONES: In other words, you are bringing up the geographical barrier factor, which well may cut across county lines in the establishment of a hospital area.

MR. BROWN: Probably that's the reason many counties in this country do not have hospitals now, because of certain barriers, such as geographical barriers and trade barriers.

MR. JONES: You may even run into such a situation as you see in Sioux City, Iowa, where the trading area cuts into three different states: South Dakota, Nebraska and Iowa. This presents a nice problem which the state survey doesn't touch, and it would be wise to have someone come in and check to see what hospital facilities are needed.

MR. AYDELOTT: Of course, the conscientious architect is interested primarily in planning a building that will intelligently meet the need and will in turn be properly used. It's very disheartening to plan a good hospital and find after the building is built that it's over-adequate or inadequate and can't be properly used. That, in my estimation, is the point of view of the architect toward the consultant, particularly in this community planning aspect—the thing that an architect has no time for nor business with at all.

ARCHITECT

Alfred L. Aydelott is a member of the Memphis, Tenn., firm of Dent and Aydelott, architects. Mr. Aydelott, who has designed a number of hospitals in the South, is a graduate of the University of Illinois College of Architecture. He worked in architectural offices in the Middle West and South for several years before establishing his own firm in 1937.

MR. JONES: Mr. Sherman, you have this problem in Evanston. You are in an area with several hospitals, serving a wide community. What did you do about having a consultant study your needs?

MR. SHERMAN: Because a hospital is operated not for profit, many people seem to think of it as an amateur effort. Certainly in Evanston, however, the trustees are highly specialized in various fields, and conscious of the need for the best expert advice we can get on all subjects. For that reason, we called in a consultant to survey not only the present but the foreseeable future needs of the community. We don't want to duplicate the facilities offered by any other institution, but we do want to meet the real needs. We wouldn't make any move there without such a survey.

MR. JONES: That brings up an interesting point. So often a hospital looks only at its immediate need, and then has something designed to meet that need. Then, five or ten years later, they find that it was nowhere near enough, and because the original plan didn't see years ahead, they get a hodgepodge building.

MR. BROWN: That's when they blame the architect when they have no right to. They insist that he plan something to meet the immediate needs and the need pocket-wise, too, and later it cannot be expanded.

MR. AYDELOTT: Down in my section of the country, I have occasion to meet with pre-appointed boards of trustees for projected hospitals, particularly now that this hospital law is under way, and invariably the men that represent the projected hospital are uninformed on any phase of hospital management or planning or any other aspect of the hospital field. About all they know is that they are eligible to build a hospital under the terms of some law, and that they can get some money to help them build a hospital, and that they are important enough to represent the community in an effort to get the hospital built. The first step, in their minds, is the employment of an architect in the construction of a building. To them, it's just another building project.

I have been very anxious to encourage the employment of someone who is conversant with the hospital field, whether he's a consultant as such or not is of secondary importance, but someone who can direct the planning on an intelligent basis.

DR. SMITH: Regardless of the type of building you work out for the present, you surely should outline a definite master plan. Whether it is ever used or not is beside the point. A master plan should be laid out with enough flexibility to provide for expansion for the foreseeable future and even for some types of services which at the moment we don't know about, such as laboratory and research.

MR. JONES: Assume we have all that, and it's pretty well understood that a certain number of beds and certain services are needed in the area. Then I suppose we get to the point of some actual design of the hospital. Now, I'm sure—

DR. SMITH: I think you are ahead of yourself.

MR. JONES: What do you think would be next?

DR. SMITH: I think first some group has to sit down and actually work out a program of what you want to do in the hospital—what you expect to accomplish, the services you want and the facilities for these services—and then have the board and the staff and the administrator agree that those are things that you want. Then talk about design. If you get into the design stage first, and begin to look at pictures, you may overlook many of the things you want.

MR. JONES: You are talking about a written, prepared program to guide the architect before he wastes a lot of time putting pictures on paper.

DR. SMITH: Not so much to guide the architect, but first to crystallize the thoughts of the board and the medical staff and other groups.

MR. BROWN: One other step, too. Before you actually put any plans on paper, you have to consider the money side. It would be useless for many towns to plan to meet their needs unless they have the money to build with and unless they have the money to support the hospital after it is built. So the program should be reviewed in terms of both capital expenditure and the annual operating expense before the actual design is planned.

MR. JONES: One of the tragic things I have seen so often is that a community will vote a bond issue for a hospital of a certain number of beds, without the slightest idea of what they really need. Then they discover that the bond issue is about a third as much money as they ought to have, and either the whole project is killed or they start cutting corners and build something that is totally inadequate.

DR. SMITH: It's an absolute necessity for someone to determine how much the hospital is going to cost. That someone will usually be the architect and/or the consultant. Then the question of the financial resources of the community comes up. The board must understand the fiscal possibilities of the community, and possibly call in some professional fund-raiser, if additional information regarding the possibilities of getting the funds is needed.

I think we should also give some thought to supporting the hospital after it is in existence. I am not overly disturbed about the support of hospitals where there are arrangements to have the state or the tax body care for indigent patients on this new governmental reimbursable cost formula. Those hospitals ordinarily should be able to break even. They will be paid for their indigent patients, and that usually takes care of the charitable work in most of the smaller communities. The other patients should pay their own way.

I think we should separate that type of hospital from the large city hospitals which have investigative work to support. You know ahead of time there will be deficits in these hospitals. But the ordinary hospitals throughout the country have been able to break even, and I think in the future we are going to break even to a greater degree because of the tax groups coming in and paying for the charitable patients.

ADMINISTRATOR

Ray E. Brown is superintendent of the University of Chicago Clinics and associate director of the university's graduate course in hospital administration. Before going to Chicago, Mr. Brown was superintendent of the North Carolina Baptist Hospital and professor of hospital administration at Bowman Gray School of Medicine, Winston-Salem, N.C.

MR. JONES: You have brought up a fundamental problem for a planning group to consider in starting a new hospital. For example, the Suburban Hospital in Bethesda, Md., and the Arlington Community Hospital at Arlington, Va., were built under the Lanham Act during the war. There were bright prospects for good hospitals in those areas, but what has actually happened is that the load of indigents—because there is no other place to send the indigents in those communities—has been so great and the payment per indigent patient day so low, that it has threatened to bankrupt those hospitals.

DR. SMITH: That goes back to the comment that if they can't find the funds, they shouldn't build.

MR. BROWN: The administrator in each of those cases, and like cases throughout the country, through no fault of his, has really caught it in the neck. The taxing body has attempted to pass on to the administrator the responsibility for taxing the sick, when they are flat on their back, for the support of the indigent. This should be the responsibility of the well taxpaying public rather than the sick taxpaying public.

MR. JONES: A group that is going to build a new hospital should have a signed, sealed agreement with the city, the county, the township, or the state—whichever unit of government is responsible—to see to it that they are paid on a cost basis for indigents. If they would do that, there is no reason the hospital shouldn't stay solvent and be able to render service.

Now, assuming that the planners have a fairly good picture of the community, its needs and its financial ability to build and support the hospital, we begin to get into the architectural planning phase. Mr. Aydelott, what should an architect expect from the community before he actually starts to put the hospital plan on paper?

MR. AYDELOTT: Well, I'm not being facetious when I say he expects a contract first.

MR. JONES: There is something in that!

MR. AYDELOTT: I have got to the point where I don't expect anything, really. I have learned that if anything is to be done as a rule on these hospital projects, the architect has to take the initiative and see that it is done, even if he has to do it himself.

It is all well and good for people who are connected with the hospital profession to decide that what ought to be done is thus and so, but that doesn't mean those things are done. And, as a matter of fact, they definitely aren't.

Our usual situation is an interview with lay people who know nothing of hospitals, with reference to awarding a commission for architectural services on a building they hope to build without any technical help whatsoever except the architect's. We rarely have a voluntary offer on the part of these people to give us assistance from hospital people. If we present the problem to them, they automatically think that we are incompetent, because, otherwise, we'd be perfectly able to go ahead and do the job. All the other architects are, so why shouldn't we? And they are not easily impressed by an attempt to show them that we want to get a good job.

But we have attempted anyway to spend a little time investigating the medical facilities at hand, and we have made ourselves fairly conversant with the state plans in the states we are doing business in. We have made it our business to get to know the people who are in charge of the state hospital commissions and tried to have some political knowledge of the community.

I wouldn't attempt to make any sort of survey out of my office, because we could never get paid for it, and I don't feel that we are called upon to sacrifice our profit, but we do try to bring someone in or encourage the people to bring someone in and pay them for doing the things we have said they ought to do. We are not always successful, and when we are not successful we don't turn the job down. We should like to be in

position to refuse it, but we feel, perhaps egotistically, that in spite of the fact that we are not able to put across the point of getting technical assistance outside the architectural field, we may be able to do a better job without it than some other architect might. But the answer to the question is that we don't expect anything.

MR. JONES: Mr. Sherman, if you were getting ready to do this expansion job at Evanston, would you expect to give the architect some kind of written program showing exactly what you want in that hospital before he goes to work?

MR. SHERMAN: Well, I was just going to ask whether your observations apply to a brand new hospital, primarily, and not to an existing institution?

MR. AYDELOTT: Oh, certainly. It is not too difficult in an existing institution.

MR. SHERMAN: With our expansion problems, we have discovered that the board is primarily an umpire over the varying demands of the departments of the medical staff. Of course, our administrator gives us lots of assistance on that, but we have made it possible for the medical staff to go directly to the architect and indicate what they think they would like to have for their particular department. Then he brings those varying plans to the board, and the board has to umpire to determine what the dollars will buy at the present time, what is the most urgent and what is not.

MR. JONES: I am not at all sure that the board of trustees is qualified to be that umpire.

MR. AYDELOTT: That's the way I'd feel about it. I'd rather have a consultant umpiring between me and the board of trustees. That would be my ideal situation.

MR. SHERMAN: Well, the board of trustees has the ultimate responsibility of making the decision.

MR. AYDELOTT: Yes, but the architect has little influence over their decision, and often he's more informed than they are. But a consultant, a man who is recognized as an expert, would be more successful in acting as a buffer or an umpire between the board of trustees, who are semi-informed, at best, and the architect, who is maybe a little better than semi-informed. Do you see what I mean?

MR. SHERMAN: We are looking to our administrator for that.

CONSULTANT

Herman Smith, M.D., became a full time hospital consultant a year ago when he retired as director of Michael Reese Hospital, Chicago, a position he held for twenty-five years. Dr. Smith learned hospital administration as an assistant to the late Dr. S. S. Goldwater at Mount Sinai Hospital, New York. He has been a consultant on major hospital planning and construction projects all over the country.

MR. BROWN: I think that the consultant, the architect and the staff should work as much as possible through the administrator. You can save a world of the architect's time if the administrator screens out a lot of the demands of the medical staff. You can be sure that each department is going to have just about three times the demand for space that can be allowed. If that can be shown by the administrator to the staff before they get to the architect, I think by all means that the medical staff should have access to the architect. And not only that, I think the architect and the consultant should have access to any department head in the hospital.

MR. AYDELOTT: The thing just about resolves itself into this sort of a circumstance: If you are building a new hospital, the architect needs a consultant for protection. If you are building an addition, the administrator needs a consultant for protection. That's about the size of it.

MR. BROWN: Let's say this, too: A new hospital would be very foolish to do anything until they employ their administrator.

MR. AYDELOTT: I can't agree with that. I ordinarily argue for a consultant, somebody who will take the responsibility of interpretation, but imagine this: We have had one project in the office for about two years that we are getting contract drawings ready for at this time. I anticipate that very probably our building will be in excess of the funds available, which means that we shall have six months or a year, or a year and a half, to wait before we can let a construction contract. We did have consultative help on it, but an administrator would certainly be cooling his heels for months at a time while we are getting set to get the building built.

MR. BROWN: I doubt that. Let's say it takes a year. The hospital administrator, say, would make $10,000. Your building these days is going to cost a million or two million dollars. You are paying out an infinitesimal proportion to get that administrator there, so you shouldn't worry about having to pay a salary for a man who is going to be there a year without patients.

You have all the spadework of community development, interpreting the purpose of the new hospital to the community, lining up with the taxing authorities for payment for charity patients, and working with the newspapers to keep the flame burning. Unless you have a board chairman who is going to spend about 60 per cent of his time with that project, I'd say you'd better get your administrator pretty early in the game before you make any contracts.

MR. JONES: There seems to be a little disagreement as to when the administrator should be employed. As a board president, Mr. Sherman, if you were charged with the responsibility of starting a new hospital, how would you feel about it?

MR. SHERMAN: I think I'd be inclined to want the administrator on the ground, because the board is going to look to him to run the institution, and he ought to have some say as to what kind of an institution it's going to be.

DR. SMITH: I am on both sides of the fence at the same time. I think the answer varies with the size of the hospital, the community and the question of whether or not you have a consultant. If you don't have a consultant, you obviously have to have someone to guide the board in the technical aspects of the hospital, whether it is large or small. If you have a consultant, in most of the smaller hospitals that I know of, there doesn't seem to be any need at all to have the administrator on the job, because the consultant can do the job as well as the administrator. Otherwise the consultant shouldn't be there. In the smaller places the administrator's salary represents a rather considerable expenditure. The administrator has to come on in time to get his organization developed and his equipment developed. That may be a long time from the time they first talk about it.

When you get to the larger hospitals where someone has to keep up community interest and continually get funds, it is important to have the man a good deal earlier than it is for the smaller hospital. Again, it depends on the type of board.

MR. JONES: It's pretty safe to say that there isn't one board out of 500 that will have anybody who really would be capable of doing that job himself. Most board members have their own jobs.

DR. SMITH: Not speaking as a consultant but just speaking generally, I believe that where the smaller hospital is going to pick out an administrator who hasn't the background in building experience, in general a well qualified consultant would be of greater use to the board—

MR. AYDELOTT: That's my idea.

DR. SMITH: —than the administrator would. The young administrator may have some very fine theoretical ideas, but it may not be too advantageous to follow them completely. The administrators picked for the larger hospitals have usually had considerably more experience.

MR. JONES: Here is another phase of planning that I think is important in an area where there are already several hospitals. The question is whether each individual hospital shall add some facilities, or whether certain hospitals should be merged, or whether some are so obsolete that they should be completely abandoned and a new plant built. Should the hospitals approach the community on a joint fund-raising campaign participated in by all the hospitals? It seems a terrible waste of effort in some instances where each hospital goes out on its own without any consultation with the other hospitals for the development of a long-range program for the immediate city or area.

The Cleveland Hospital Council made a study of the needs of Cleveland and then drew up a master plan which all hospitals agreed to. Then they went out on a joint fund-raising campaign. Another interesting example is the town of Hutchinson, Kan., where the Methodist Hospital and the Catholic Hospital got together on a successful joint fund-raising campaign which seemed to make an excellent spirit in that town and eliminated some of the needless competition between hospitals.

MR. SHERMAN: I agree that there should be consulting all the way around so there is no duplication of facilities, but as far as the actual raising of money is concerned, it seems to me that each hospital has its own individual following and that the aggregate of the efforts of all the hospitals would be greater if it wouldn't merge into one. Some people will want to give to a single institution and not to the picture as a whole.

TRUSTEE

Robert T. Sherman, Chicago attorney, is president of the board of trustees of Evanston Hospital, Evanston, Ill., which is about to launch a $5,000,000 building program. Mr. Sherman is also president of the board of directors of Chicago's Blue Cross Plan for Hospital Care and has been a trustee of the Chicago Hospital Council. He is a graduate of Harvard University Law School.

MR. BROWN: I don't believe it will work, either. You have a following for hospitals just like you do for schools or churches or anything else. You go out after big money, and you are going to find that people who give to their own hospital will give only a nominal amount during a city-wide campaign, holding their gifts back until the accounts are all settled. Then they come across. There is competition not only between hospitals, but there is competition between the hospitals and the colleges. A person may give more to a college than he would to all the hospitals in the city, yet he would give more to one specific hospital than to a college. I want to hear more about what has happened in Cleveland, because I think this is going to be proved in Cleveland.

You have competition for the dollar from all sources, unless you make an appeal to patriotism or loyalties or religious ties or some basis stronger than just community good, because very few of us—and I mean very few of us—are capable of thinking in terms of the common good of the community. It takes an awfully big fellow to be able to do that and, of course, there are not too many big fellows.

DR. SMITH: I think everyone should know what the theoretical needs of a community are, but the whole history of voluntary hospitals has been one of individual effort, and I think that individual effort should continue. When you try to make a mass effort, the thing we accomplish isn't a leveling up but a leveling down. Maybe the efforts you speak of are exceptions.

I believe those hospitals which have either funds or connections or services or medical staffs which are outstanding should continue to develop and perhaps far outstrip their sister hospitals in the community, because I think the general level of medical care for that community is going to be much better if the better hospitals are able to go all out for what they can do. The others perhaps can still drag along and help, instead of taking from the good hospitals and bringing it down to some poor ones which may always be poor. I am definitely for the individual effort!

MR. JONES: Mr. Aydelott, do you want to come in on that from the standpoint of what you have seen in your part of the country?

MR. AYDELOTT: That's a little out of my field. The only opinion that I have on the subject of funds is there should be more of them.

MR. JONES: Would there be any fundamental disagreement on the general thesis that no hospital should go ahead on an expansion or building program until a careful study of the whole area's needs has been made?

DR. SMITH: I don't even believe that is true. It's a nice thing to have, but let's take certain hospitals which have a clientele that may have nothing at all to do with that particular area. We know there are many hospitals in the country that pull from far beyond their trading areas, geographical areas, or anything else. Those people know what they can do or should know what they can do. If they do a better medical job and satisfy their desires and the medical staff and make contributions to medicine, I think they should go right ahead.

MR. JONES: But isn't there danger of one hospital doing that and keeping on adding to its size until it gets to be so big that patients lose identity? Might it not be better in some instances to have a hospital develop up to a certain size and then stop enlarging and attempt to bring some other hospitals in the area up to the level of the first hospital?

DR. SMITH: You can't play God. If this hospital can expand, fine, let them do it. If they get up to the place where they begin to decay—

other places have decayed. If they have made their contribution during their upsurge, that is fine. If they stop, if something happens to them at that time, it is unfortunate. Some other group outstrips them, and they go back. That's life. That happens in medical institutions. It happens in hospitals; it happens in industry. I don't see anything wrong with it.

MR. BROWN: That's the thing that worries me about the way we have hung on to the word "planning" in the last few years. Who is going to determine when the hospital gets too large? After all, that's up to the patient. If I go to a hospital and I am not treated as a human being because it is too large to give adequate service, then other hospitals in the city are going to attract me. They are going to expand to meet the needs of the patient. I would hate to have this country get into a situation in which we plan everything from the top instead of allowing competition so that a patient has an alternative. Let's leave the patient a choice. Of course, we don't want that margin of choice to be so large that there are many vacant beds, but if each hospital can grow, the patient and the doctor will make the final decision as to further growth. I think they are the ones to make it, rather than an advisory board.

DR. SMITH: You are speaking of the private hospital, not the public hospital?

MR. BROWN: Yes. I think the public hospitals should attempt to meet only those needs in the community that voluntary effort cannot meet.

MR. JONES: How would you feel about a county determining to build a hospital of 100 or 150 beds to take care of the indigent, and then having some voluntary group or church group come in and build a hospital of 150 or 200 beds to take care of the people who can pay? Is that as sound as combining care for all the people in one larger hospital?

DR. SMITH: Better have two, if they are fair size, in order to have legitimate and reasonable competition. If we have the only place to which people can come, we have a type of monopoly, and we are human, so we sit back on our haunches and let things go a little bit. Many industries have two competing setups within themselves in order to keep their component parts on their toes.

The extra cost to the community, particularly when the two hospitals divide pathologists and x-ray people and so forth, isn't so stupendous, and maybe that cost is much better in the long run than it would be to consolidate the hospitals.

MR. JONES: That might be reasonable if you were going to have two pretty good sized hospitals, but if you were going to have two or three 75 or 100 bed hospitals and no one of them too well staffed or too good, a great many people think the community would be much better off if it had one good 150 or 200 bed hospital.

MR. AYDELOTT: Not only that, but I don't see that you can argue in the direction of separate hospitals without arguing that charity patients are entitled to one type of hospitalization and people who can pay are entitled to another type. I don't see how you can put a tax-supported institution in to handle charity cases and a voluntary hospital to take care of pay patients and expect the level of care to be the same in both cases.

MR. JONES: We know that we are going to get a better staff of interns and residents if we have some wards for indigents, and if you do get a better house staff then automatically the paying patients in the hospital also get better care. I think you can make quite a case for seeing to it that indigents and pay patients are cared for in the same hospital.

MR. BROWN: I don't think that Dr. Smith meant to have the city build an all-charity hospital and someone else build one to take care of the pay patients. In many sections of the country, the city hospital or the county hospital is not entirely a charity hospital but is also a hospital serving pay patients. Often, of course, it would be foolish for the city to build a small free hospital. But when you get in a city the size of Chicago, then the county should do its own planning, irrespective of what voluntary agencies are doing in regard to the welfare of the poor, if they think they can take care of the poor cheaper.

MR. AYDELOTT: Of course, this is a pretty involved sociological question. I don't see how you can separate the two classes of patients.

DR. SMITH: I don't think any separation is meant. I was going on the assumption you have two 150-bed hospitals in the community, caring for all types of patients. Should they be combined into one 300-bed hospital? My answer is "No." If there is an opportunity to build two 150-bed hospitals in a community, instead of one 300-bed hospital doing the whole job, I think they should build two 150-bed hospitals. They will be doing it eventually anyway, because there will be a group of dissidents or a particular religious, fraternal or medical group which will start building up another competing institution, and communities usually want that sort of thing and are better off for it.

MR. JONES: On the other hand, isn't there some point there in efficiency of operation? I don't know where the dividing line is, but certainly it is more costly to operate a 75-bed or 100-bed hospital and give good service than to operate a 300 bed hospital and give good service.

DR. SMITH: Let's go back to the record. The records show that the cost of running a small hospital is usually lower than the cost of running a large hospital.

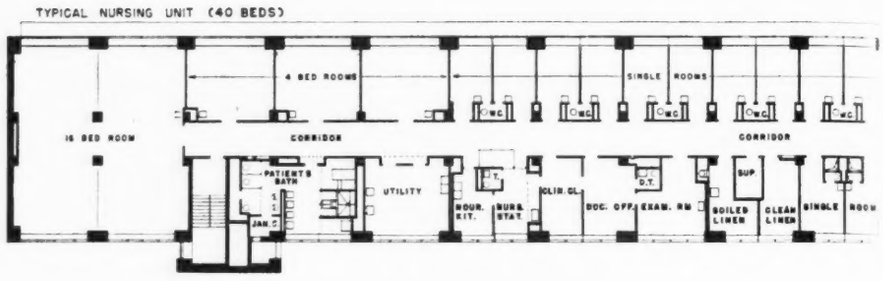
MR. JONES: But not if comparable service is given.

DR. SMITH: Possibly, but that is also questionable, because you are dealing in the theory of what services the patients want, and what services the doctors want. Theoretically, you can say the doctors in the smaller hospitals are getting the services they want. I don't think the argument of lower costs in larger hospitals holds. I think the argument of higher costs in larger hospitals holds, because they become involved and want more service. Some of the services may be necessary. But even agreeing that it may be more costly to run two institutions than one, I think frequently it's a better expenditure for the community

(*Continued on Page* 90.)

MODERATOR

Everett W. Jones has been vice president of The Modern Hospital Publishing Company since 1943. A graduate engineer from the University of Wisconsin, he was administrator of Albany Hospital, Albany, N.Y., for ten years, then became chief hospital consultant for the War Production Board in 1942. In this capacity, Mr. Jones visited and inspected hundreds of hospitals throughout the United States.



A typical nursing unit of the Veterans Administration hospital, Fort Hamilton, Brooklyn, showing the patients' rooms oriented to the south.

BASIC CONSIDERATIONS IN HOSPITAL DESIGN

I. ENVIRONMENTAL FACTORS

NATHANIEL A. OWINGS

Skidmore, Owings and Merrill
Architects, Engineers
Chicago

THOSE who deal with the planning of hospitals have tended to create an air of mystery about the methods of arriving at solutions to the problems. They have tended to associate with the hospital planning an impression of such great complexity as to suggest that only a few great minds are competent to tackle the job.

This situation has resulted in inhibiting to a great extent the development of a younger generation of hospital designers in this country. It has discouraged considerably the development of innovations and has tended to thwart what in other fields of endeavor might be considered normal processes of research, experimentation, invention, and perhaps even improvement in the basic concepts of design. In other words, the leading hospital authorities of the country today were the leading hospital authorities fifteen years ago, and yet, during the period from 1930 through the depression and the war, great strides have been made in technological fields. Naturally, the question arises, "Are the benefits derived from these improvements being incorporated in the hospital designs which are on the boards today?"

In an effort to outline a rational approach to the problem of developing a truly contemporary hospital, the controlling factors in the design of such a plant can be isolated and stated in clear and simple form. These are (1) environmental requirements, including site consideration, orientation of patients' bedrooms, and sound control; (2) efficiency of operation, and (3) economy of construction.

If accurate, adequate and imaginative answers can be given to each of these three basic considerations, the result would have to be an ideal hospital.

The hope is that all three groups of requirements can be answered and composed in one harmonious amenity, with no compromise required within or among them; that no fundamental in one group will cancel out a fundamental in another—so that efficient operation will not preclude orientation, for example, or economy of consruction will not rule out desirable environmental criteria.

The question of listing these three factors in the order of their importance arises. We shall assume that such an arrangement is parallel, that no one is more or less important than another, and that a mutation can be accomplished so that all three may slip, like well machined parts of a motor, easily and quietly into their proper places, and the motor may then begin to purr.

In order to provide sound, uninhibited solutions to the three controlling factors, a method of procedure must be established. In establishing such a procedure it seems reasonable to assume that a perfect hospital has yet to be built. It seems reasonable to assume, further, that the procedures followed by our great educational institutions and by industry itself might lend a clue to a logical approach to our specific problem.

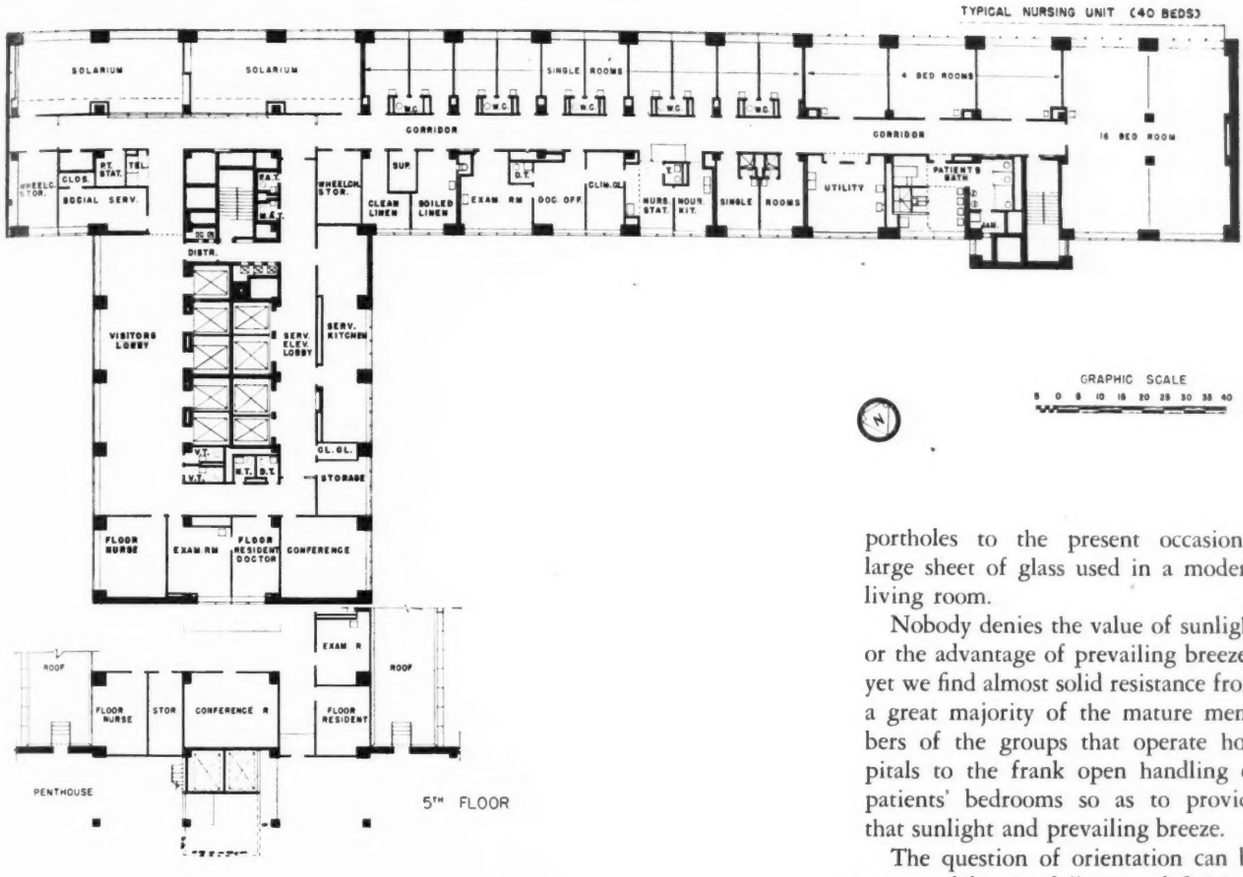
We shall assume, first, that we know nothing about a hospital. We shall turn to the raw material, the basic factors which constitute, when properly combined, a solution to our problem. We shall turn, in other words, to basic research.

1. Basic research is the study of the fundamental factors from which formulas are developed. It means going back to the fundamental areas of knowledge, to what actually happens to people—patients, doctors, nurses. What is the flow of the product, so to speak? What are the processes to which the product is required to respond—the development in the sciences behind the process, chemistry, nuclear physics, radiology?

Basic research has the same relation to hospital planning that the physicist has to the engineer. It is where the engineer derives his formula. It involves the human being, the study of the physiology of that human being, and a related study of psychology. It involves writing a program of what should happen to that person during his stay in that medical center, not in terms of equipment, building materials or medical technics but in desired results in which the factors just mentioned are the tools but they must be fashioned from the basic research.

2. When this basic research has resulted in a program, then the industrial, or applied research, phase begins. Applied research is the application of the basic research to the problem in terms of a specific specialty, such as the ancillary services or the patients' bedrooms. Under applied research we

This is the first of three articles by Mr. Owings on factors controlling hospital design. Later articles will deal with "Fundamental Qualifications of Design" and "Building Materials."



have the writing of a program for the special project concerned resulting in flow charts, allocation plans, and relationships in terms of logical procedure, still, however, without relation to physical limitations of site or plant.

3. The interpretation, three dimensionally, of the product of the applied research and basic research phases and their resulting program brings us to a third phase, that of physical plant design. This is the practical harmonizing of the programming, applied research, and the actual site conditions and uncontrollable external limitations. Now, and not until now, can the actual plant design be properly prepared.

Now, with these definitions of the tools we shall proceed to examine the question of environmental qualifications. Basic research quickly indicates that all life stems from the sun and the earth. These two factors create what is called the environment of the physical plant. It seems clear that the proper relationship between our physical plant and the earth and sun must be solved in order to produce the environment needed. This sounds so simple and obvious as to be almost ridiculous, and yet if our current cities are any indication of the understanding that now holds for site planning and orientation in the matter of finding a decent environment in which to live, then obviously those two great qualifications have been consistently either misunderstood or ignored almost entirely over the period of modern building.

We have two methods of arriving at proper environment. One is decentralization, moving the building to the country, or clearing blighted areas within our cities of such size as to permit the reestablishment of a suburban character—a place, in other words, where grass and trees can live.

Land has no value except in terms of its productive power. Here in the United States land is one of the most plentiful of our natural resources. Building sites should be large. Specifically, the gross area should be at least ten times that of the floor plan of the project involved. With the site sufficiently large to permit a gracious, open type of planning and to permit expansion in the future, we have established our environment. We have individuality! We are free of obstructions on all sides, permitting beneficial light, air and view.

Then the question of orientation arises. Even in the brief history of our own country the fenestration provided by man for his shelter in less than 150 years has changed slowly from tiny portholes to the present occasional large sheet of glass used in a modern living room.

Nobody denies the value of sunlight or the advantage of prevailing breezes, yet we find almost solid resistance from a great majority of the mature members of the groups that operate hospitals to the frank open handling of patients' bedrooms so as to provide that sunlight and prevailing breeze.

The question of orientation can be answered by the following definition: "The design in relation to the patient's bedroom so as to obtain the maximum 'controlled' use of the sun and prevailing breezes in order to obtain the maximum therapeutic value to the patient." Orientation, if consistently carried through, provides an answer to many otherwise difficult and controversial questions. If orientation is essential, then all patients' bedrooms must face in the same direction. This settles the shape of the structure. It demands a simple rectangular structure without expensive breaks, dark corners, complicated structural systems.

This requires that these bedrooms be in a straight line. This would appear to many who belong to other schools of thought to create longer distances for the nurse to walk. It brings up the question of conflict between orientation and functional efficiency.

Our plan places all the bedrooms on one side of the corridor which immediately eliminates the question of across-the-corridor noise, provides direct ventilation for each room, permits the placing of utilities close at hand, and reduces the length of travel of the nurses. Modern hospital technic and practice assimilate almost all of the space on the north side of the corridor not already taken up by elevators, stairs and other service facilities.

Above, left: Steel structure of the V.A. hospital at Fort Hamilton. Right: Architect's rendering of the hospital. Below: Scale model showing site plan of the hospital.

With the nurses' station located in the center of gravity of the bedrooms, they actually have less distance to travel than that provided by any other floor plan we have seen.

Opponents of this plan base their objections on the excessive use of glass, claiming that the heat loss in winter would be great and that the strong summer sun and light would be objectionable to the patient. A permanent canopy or awning has been developed that admits sunlight in the winter and bars the hot sun in the summer.

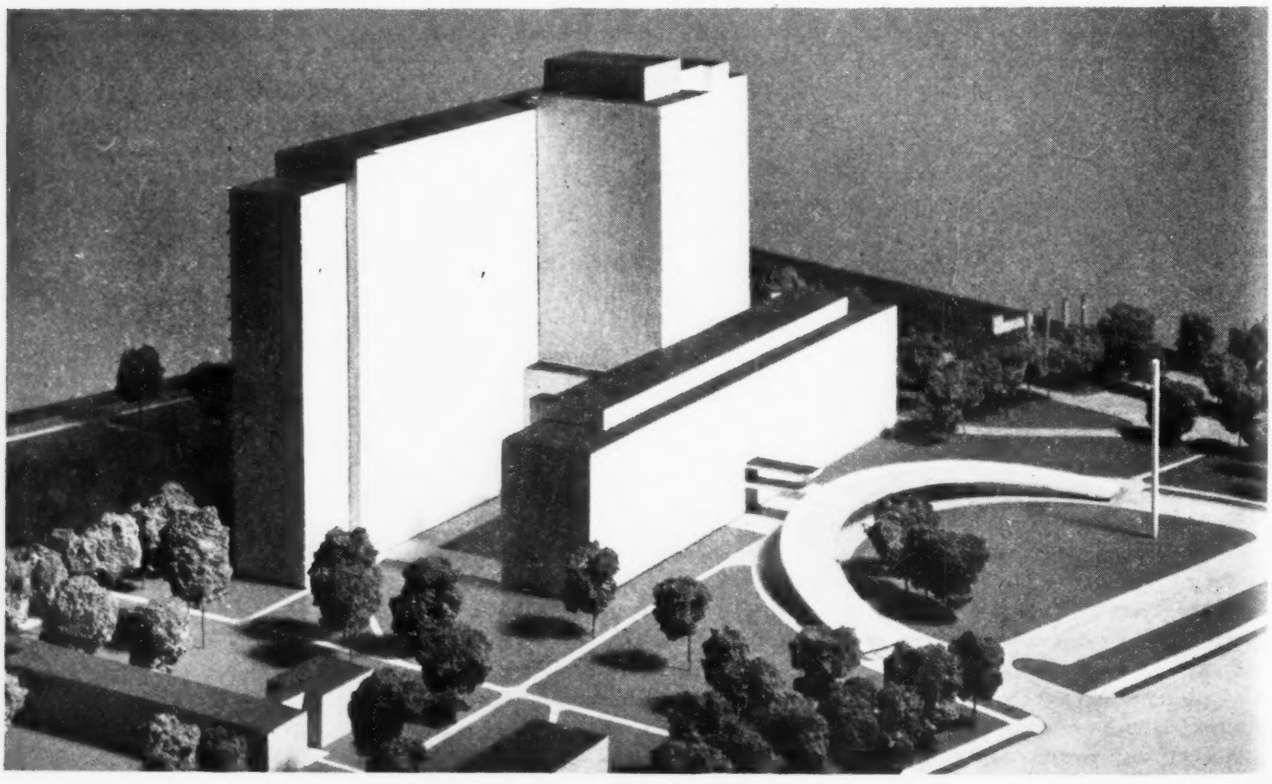
Others decry the factory-like, monotonous appearance of our hospital. We can only point out here that our chief aim is to find a functionally perfect plan, and once that has been attained we see no reason why that plan should not be repeated again and again in other localities.

One of the major advantages of our plan is its economy of construction which is apparent in its development of the ideal section, its clean, simple detailing, and the sharp separation of the structure from the glass and metal walls. This economy is repeated in the ease of installation and in the maintenance and operation of the hospital.

Another advantage is the wide and open two-bed ward featuring relatively large amounts of glass, usually 8 by 10 or 8 by 12 feet. Here, the occupant of the second bed shares the view.

Since these glass areas can always be reduced or expanded by the use of curtains, there is complete flexibility regarding the amount of sunlight desired.

The final judgment rests with the patient. He is the one who must pass final approval on our hospital plan. We feel that a man who seeks the sun when he is healthy and active is hardly going to hide from it when he is ill. Rather, we are confident that he will follow his natural instincts and "turn toward the sun."



PROGRAMMING
PLANNING
CONSTRUCTION
AND THE ROLE OF THE ARCHITECT

Continuing a Study by the
Division of Hospital Facilities
United States Public Health Service

THE previous articles in this series have been concerned mainly with the design of the hospital. This article will outline the entire normal construction procedure through the various stages of preparation of program, planning the building, development of working drawings, award of contract, and the construction and equipping of the completed building.

The early employment of an architect is one of the first requirements for planning a successful building project. Signing of a contract with an architect for the design and supervision of the hospital construction will help assure that the details for which he is responsible in the preparation of the project will be more efficiently expedited.

The hospital building is one of the most complicated problems in planning and construction. An understanding of the various phases involved should make it obvious that the complete cooperation of the hospital board, administrator, architect, consultant and building contractor is necessary to guarantee the success of the project.

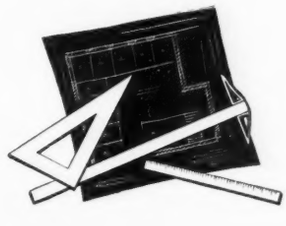
PROGRAM STAGE

Before any planning can be done by the architect, an understanding of the requirements of the hospital must be agreed upon. A hospital administrator or consultant can furnish assistance in determining the hospital needs of the community, on problems relating to the planning, maintenance and operation of the hospital. The number of beds required and the types of services to be offered will be affected by the extent of other existing facilities in the community. When the number of beds required and the services to be offered have been decided upon, a program should be developed. This program will show with reasonable completeness the requirements of each department of the hospital as to approximate area, major equipment and personnel employed in each department. These needs should be discussed at length by the hospital administrator, the department heads, the architect and consultant.

From these discussions a written program should evolve which will clearly state the requirements of the hospital. Too much emphasis cannot be placed on the importance of this preparatory work. If the problem is clearly thought out at this stage of the project, much time and money will be saved, and a better planned hospital will result.

SCHEMATIC STAGE

When the program is complete, and the hospital board and architect have selected the site of the building, the architect may proceed with the next step of planning which takes the form of a small scale schematic drawing. He will translate the information in the program into terms of building area required, study the relation of the various units and traffic flow among them, and from this the size and shape of the building will evolve. Based on the program and subsequent study by the architect the result should be a fairly accurate concept of the final form of the hospital. This plan should be well studied by all concerned, and any changes should be incorporated into the plan at this time.



After the schematic drawings have been agreed upon the architect can make a fairly accurate estimate of the funds required. This estimate should include the cost of construction of the building, fixed and movable equipment, architect's and consultant's fees, inspection and supervision, grading, walks, roads and landscaping, and contingencies.

PRELIMINARY DRAWING STAGE

After the schematic drawings and the cost estimates have been approved, the architect will develop the plan at a larger scale indicating major items of equipment on the plan. During the preliminary planning stage the architect and his structural, mechanical and electrical engineers have been studying the requirements to determine the most economical and practical systems of foundations, structural framing, plumbing, heating, electric wiring, ventilating and air conditioning, and other engineering problems. They must determine which type of fuel is most economical in the particular area, which types of elevators and con-

trol devices will be most satisfactory, which materials are most suitable from the point of view of economy, function and maintenance. These questions must be decided before proceeding with working drawings.

Some changes may develop as a result of this more detailed study. The architect should now make a more nearly accurate estimate of the costs involved and advise if any adjustments in the budget for the project should be made.

During the planning phase the architect should have given those concerned ample opportunity to study the drawings and make any necessary changes. During this period all thinking has been clarified and crystalized in the form of the larger scale preliminary drawings. After approval of preliminary drawings, no major changes should be made. The architect may now proceed with certainty on the development of working drawings and specifications.

WORKING DRAWING STAGE

The function of the working drawings is principally to convey to the contractor and his workmen all details pertaining to the construction of the building. They are drawn to scale and include all information that may be more comprehensibly presented by drawings rather than by the specifications. A complete set of working drawings will be divided into architectural, structural, mechanical and electrical sections as follows:

ARCHITECTURAL — Location of building (plan of site). Existing and finished grades, roads and walks. Utility connections. Floor and roof plans. Sections. Exterior wall elevations. Large scale details of particular items. Schedules of doors, windows and finishes of all rooms.

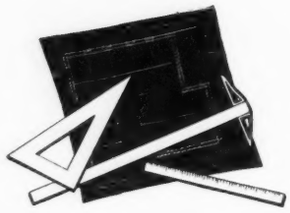
STRUCTURAL—Location and size of foundations, footings, columns, beams, girders and slabs.

MECHANICAL — Diagrams of all piping. Details of all heating, plumbing, ventilating and air conditioning work.

ELECTRICAL—Diagrams of all electric feeders, locations of electric panels, fixtures and other electrical equipment.

Specifications. The specifications supplement the drawings and prescribe qualities of materials and workmanship to be furnished by the contractor.

The specifications furnish all the



information not shown in working drawings and define work required under the contract. Anything omitted from the drawings and specifications cannot be required of the contractor. The specifications should be written in simple, accurate language and divided into sections corresponding to work performed by the various building trades and subcontractors.

Legal Forms. In addition to covering the requirements for building materials and workmanship and scope of contract, the specifications include or describe the legal forms which are to become a part of the contract. The "General Conditions" of the contract is a legal document which prescribes the methods of administering the contract and the responsibilities of the owner and contractor regarding such important items as time of payments to contractor, bonds to be furnished by contractor, insurance to be carried and by whom, protection of owner against liens if contractor fails to pay his bills, and similar legal provisions.

The preparation of the working drawings, specifications and legal documents proceeds simultaneously. The architects, engineers and specification writers work together to complete the set of documents. During the latter part of this stage it is necessary to check further on construction costs.

The working drawings, specifications and legal forms prepared for a construction project represent the final decisions as to the design of the project and methods of administering the contract. They are prepared by the architect to provide a detailed picture and statement of all work to be done, methods to be used, equipment to be furnished, and responsibilities to be assumed in order to complete a building or project. It is from these documents that the contractor prepares his proposal for erecting the building. It should be remembered that a contractor cannot be held responsible for any portion of the work not included in these contract documents.

AWARD OF CONTRACT

Duplicate sets of the completed plans and specifications are now distributed to contractors by the architect with an invitation to bid competitively for the job. It is customary for sealed bids to be submitted and opened publicly at a stated place, date and hour with all bidders invited to be present. The award of contract is generally made to the lowest responsible bidder. The contract is based upon the contractor's bid price for work included in the contract documents to be performed within a stipulated time. The architect, with his knowledge of construction contracts, surety bonds and other legal and business matters involved, usually handles the details of awarding the contract. The owner agrees to make payments for the work at the times required by the contract and to provide supervision of the work, usually by the architect.

CONSTRUCTION STAGE

Following the award of contract, the successful bidder begins work on the project, subcontracting much of it to other contractors. However, the overall responsibility rests with the general contractor.

The architect generally supervises the construction work for the owner to see that all work is done according to the contract, that the specified materials have been used, and that the work has been done in a proper, workman-like manner. Inasmuch as he has prepared the plans and specifications he is thoroughly familiar with the work to be done and is most competent to supervise the construction.

On large work it is desirable that the owner hire a superintendent selected by the architect who spends his entire time on the project working under the direct supervision of the architect. Smaller work finds the architect supervising the construction himself through frequent visits.

Owing to the complexity of the mechanical equipment in hospital projects it is highly desirable on the larger projects for the owner to hire a mechanical engineer under the supervision of the architect to remain on the site continuously to superintend the installation of mechanical equipment.

Should unforeseen and unpredictable circumstances arise during the construction of the project, changes and contract modifications will be nec-

essary. The architect will then modify the drawings and specifications and obtain such adjustments of price, time and other contract requirements as are required.

When all work required by the contract is completed to the satisfaction of the architect, he certifies to the owner that final payment is due to the contractor.

EQUIPMENT

Generally, all items of equipment which are attached to the building or to mechanical services, such as cabinets and counters, sterilizers, kitchen and laundry equipment, are included in the construction contract, and the architect assumes responsibility for their installation in the building.

Such equipment as furniture, surgical apparatus, diagnostic and therapeutic equipment, china and silverware, utensils, surgical instruments and linen is not usually included in the construction contract. These items, as a general rule, are the responsibility of the hospital administrator or consultant.

Adequate funds for equipment and supplies that are not a part of the general contract should be set aside at the outset and should not be diverted to other use under any circumstances.

Furniture and movable equipment lists prepared during the planning phase of the program are usually translated into purchase orders soon after the award of the construction contract. Delivery instructions are keyed to building completion schedules. If building delays are encountered, suppliers of furniture and other equipment should be notified to delay shipments accordingly. Complete arrangements for storage of supplies on the site should be made to prevent interference with construction work and provide protection against weather, theft and damage. Schedules should allow for ample time to uncrate, check and assemble equipment, and to place it properly in the finished building.

CONCLUSION

It must be kept in mind that economy of operation and maintenance over the life of the building, as well as the proper provision of the hospital services required by the community, is dependent in large measure upon the adequacy of the physical plant and is more important than initial economy of construction. Time and effort spent in the planning stage will be repaid many times over not only by reducing the expense for changes during the construction stage but also by providing a facility capable of being economically managed.

THE FACTORS THAT AFFECT

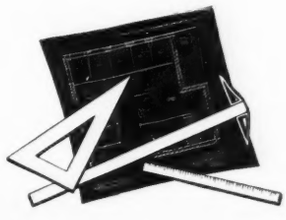
Costs

Continuing a Study by the
Division of Hospital Facilities
United States Public Health Service

UNDOUBTEDLY the most frequently heard question about any hospital project is "What will it cost?"

The hospital board asks it first, during preliminary discussions, in order to work out a practical compromise between economy and hospital needs. The building committee asks it again in order to establish a tentative budget covering the site, building, equipment and improvements. The fund raising chairman asks it before he decides on the type and extent of campaign necessary to finance the project. The architect also asks it several times while the drawings are being prepared as a check on the preliminary estimates and as a guide to the building committee. And, of course, the man on the street asks it with a feeling of community pride as he discusses the new hospital service which will mean so much to the community.

Unfortunately, there is no simple answer to this question. When complete working drawings and specifications have been prepared, a fairly definite figure can be arrived at by obtaining a number of competitive bids. The actual cost will vary from these bids by the amount of "extra" work which is caused by changes or unforeseen problems as the construction progresses. Thus, the total cost of a hospital project is not known with accuracy until the project is completed, and all the bills are totaled.



These bids, however, will come too late to answer the questions of many of the people involved. For many purposes, it is necessary to make a fairly accurate estimate of the probable cost soon after the inception of a hospital project.

The commonest method of estimating hospital construction costs has been the so-called "per bed" method—so many beds at so many dollars per bed equals the construction cost. Whether or not this method was adequate in the past, it certainly cannot be applied to any group of hospitals today and provide a reliable result. The complexity of the average modern hospital, which is planned to serve the special needs of the individual community and is integrated with other

existing medical care facilities, will preclude the use of any estimating method as general as this.

The functions of the modern hospital have expanded to include greater diagnostic, therapeutic, educational and administrative facilities in varying degrees, items which certainly add to the cost of the hospital but do not add to the bed capacity. Certain hospitals will be predominantly domiciliary institutions. Others may have comprehensive diagnostic and research duties which greatly overshadow the other departments. Classroom and educational facilities, including residential quarters for interns and nurses, may be required for certain institutions. Extensive outpatient and clinical facilities may be especially important for some projects. Some hospitals may need unusually large administrative departments to include health department and public health education activities not ordinarily accommodated or anticipated.

Adjunct facilities may have to be designed to accommodate an additional patient load anticipated as a result of future expansion, and to accommodate ambulatory patients coming to the hospitals for diagnosis and treatment. Obviously, the complete service performed by one hospital may be vastly different from that performed by another. Another factor shows that the gross area in square feet per bed will vary inversely with the size of the hospital (see Figure A). This will tend to increase the unit price, if computed on a per bed basis, of the smaller institutions as compared with the larger ones. General comparisons of cost, therefore, are seldom valid and certainly cannot be made on any rule-of-thumb method such as that of cost per bed.

To achieve their intended purpose, cost estimates should be more realistic, particularly during the preliminary stages of a project. However, before the architect can begin the preliminary study of his work in developing the hospital project, a specific program must be established, based on an accurate survey of the community needs. At this time, questions and discrepancies in the program are discussed pro and con until the hospital authorities and the architect have a rather complete picture of the size, type and extent of facilities, equipment and construction materials contemplated.

With this information the architect is able to prepare rough schematic drawings and outline specifications for the project. Then it is possible to apply a square foot price to the area or a cubic foot price to the cubage of the building and get a reasonably close estimate of what the building will cost in that locality. This estimate should include, in addition to the cost of construction of the building with its necessary plumbing, heating, ventilating and electrical work, the cost of the fixed equipment, such as cabinet work, kitchen, laundry and sterilizing facilities, boiler plant, and elevators.

Allowance must be made for architectural and engineering fees, unusual soil conditions affecting foundations, service connections, site work, such as grading, walks, roads and landscaping, and contingencies. In addition, provision must be made for the cost of movable equipment including furniture, medical equipment, and such expendible items as linens, utensils and drugs. The list of this equipment is usually furnished by the administrator of the hospital. Figure B indicates the approximate disposition of elements which make up the total cost of a project, not including site costs.

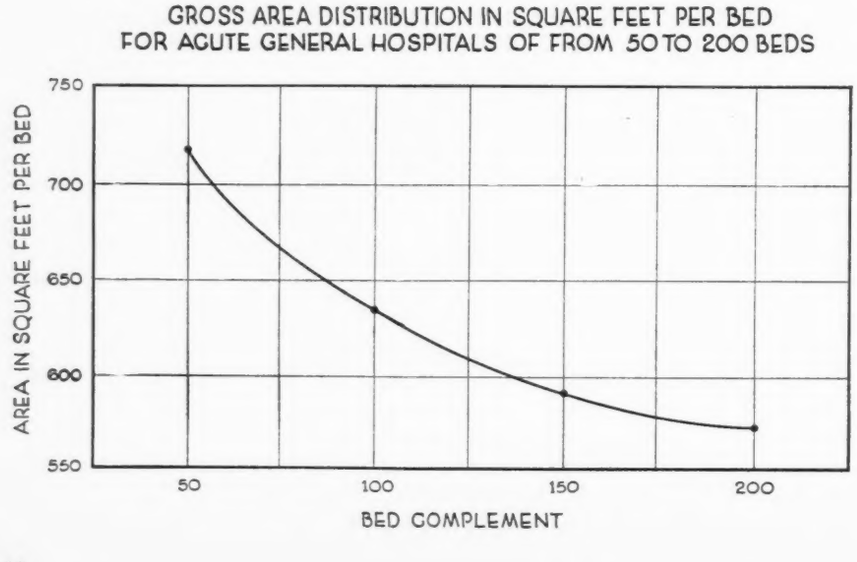
The following is an itemized list of factors that must be considered in the costs of a hospital project.

Typical Units of Cost in a Hospital Facility

1. Work to be covered by drawings and specifications (construction contracts): building with fixed equipment, contingencies for minor changes in construction, and site improvements, except landscaping
2. Depreciable and nondepreciable equipment: furniture, medical equipment, kitchenware, linen, drugs
3. Site survey and soil investigation
4. Architect's fees
5. Supervision and inspection at the site
6. Consultant's fee and other expenditures in connection with construction and equipment
7. Total construction and equipment of the hospital building
8. Acquisition of site
9. Landscaping
10. Off-site improvements
11. Legal fees, fund drives

A reliable preliminary estimate enables the fund raising committee to proceed with the assurance that the amount raised will be reasonably close to the actual cost and avoids the necessity of going back to the community for more money. Due allowance should be made for the fact that construction costs have now reached unprecedented levels. Figure C indicates the trend of construction costs from 1915 to the present time, showing rather plainly the sharp increase

FIGURE A.



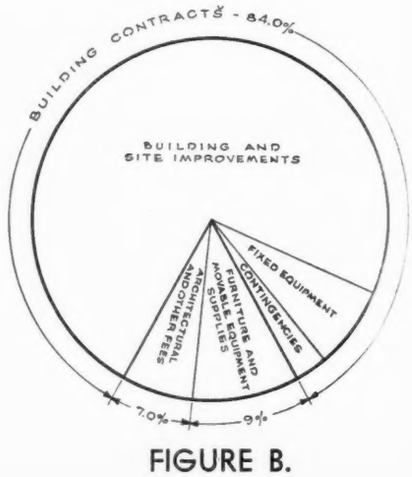


FIGURE B.

FIGURE C

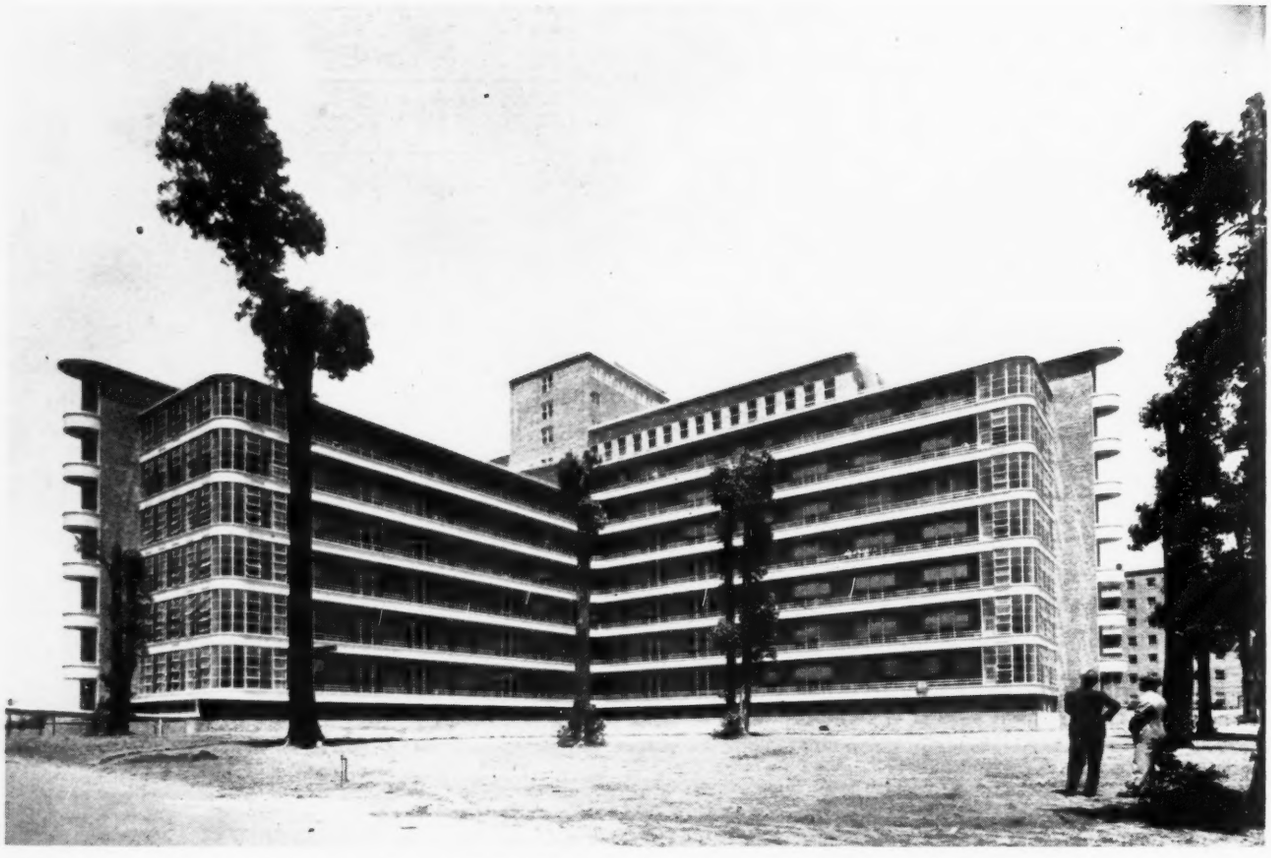
that has taken place during recent years.

It shows, for example, that while a 100 bed general hospital with a total gross floor area of about 60,000 square feet (600 square feet per bed) may have cost $500,000 for construction and fixed equipment before 1937, or $5000 per bed, it will now cost about $1,000,000, or $10,000 per bed, amounting on the average to $16.50 per square foot of total gross floor area, or to $1.50 per cubic foot of volume of building. To this will have to be added the cost of movable equipment, furnishings, architect's fees, site improvements and minor changes required during construction, amounting to about 20 per cent of the foregoing cost; and other indeterminable costs for acquisition of site, landscaping and off-site improvements. It is evident that estimates for future work must reflect these increased costs in order to provide complete and adequate information.

When the rough schematic drawings have been approved, the architect can proceed with the preparation of more nearly accurate preliminary drawings. A closer estimate of the costs should be prepared, and the previous estimate can be revised if necessary.

During the preparation of the final working drawings and specifications it will be possible to get accurate figures on construction material, quantities, fixed equipment and furnishings. This survey should be made when the drawings are about three-quarters finished and will provide a final check on the project before bids are received. If indications show that the costs are going too high, it is readily possible at this stage to make any revisions required to bring the project within the limit of available funds.

When adequate control of all cost factors is maintained throughout the planning stage, as outlined, it is relatively certain that the actual cost of the hospital will more closely approximate the budgeted expenditures.



MAIN BLOCK FROM NORTHEAST, SHOWING SOLARIUMS AT ENDS OF WARD UNITS.

REPATRIATION GENERAL HOSPITAL

CONCORD, NEW SOUTH WALES

A. G. STEPHENSON
Stephenson and Turner
Architects
Melbourne, Australia

THIS hospital was known as the "113 A.G.H." until three months ago when it was taken over from the military authorities by the Repatriation Commission under whose care come those distressing casualties which are inevitable just so long as wars are waged.

It is not often that we are able so quickly to appreciate acts of wise policy which our governments put into effect, but this is one instance where we have to thank the vision and the pluck of the then government for its decision to build these permanent hospitals long before the result of this last war could be predicted.

BED ACCOMMODATIONS

This is the largest of the permanent military hospitals that have been built in this country. It is a multistoried unit which forms a part of a hospital group containing 1800 beds. A large number of these beds are accommodated in the temporary section of the hospital, the multistory block being designed to accommodate 600 beds only. It is a military hospital pure and simple with large open wards, ample sunlight, and restful atmosphere.

BALCONIES

As the climate in Sydney for seven or eight months in the year is warm and generally pleasant, the large wards are provided with triple-hung windows which open from floor level onto the balconies outside. These balconies are designed to protect the glass from the direct rays of the sun and are not intended to accommodate beds. When the windows are wide open on either side the effect is of an open air ward in the truest sense of the word.

NURSING UNITS

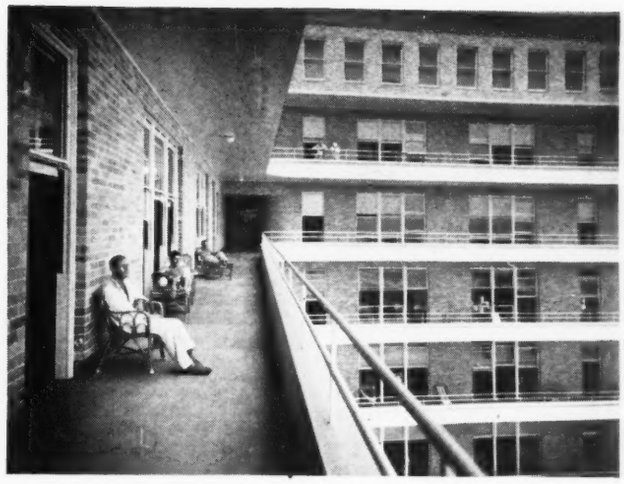
Each ward floor contains three nursing units of thirty-two beds. The items of special interest are as follows:

1. The single floor pantry unit from which food is distributed by trolley service to each ward. This pantry is in direct lift access from the kitchens below.
2. The centralized floor linen supply.
3. The single floor sterilizing unit.

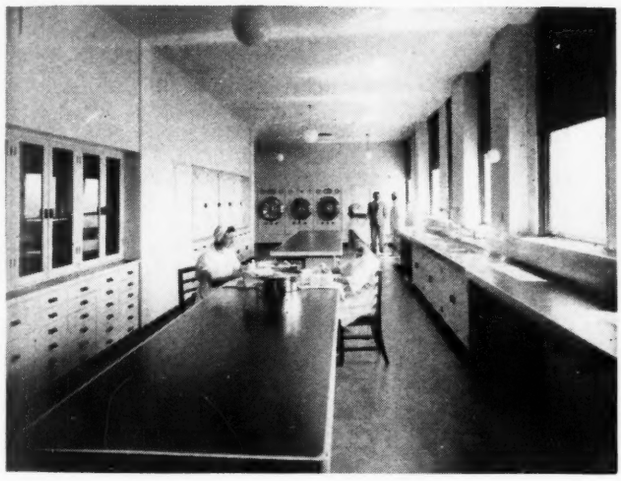
A central sterilizing department is established on the operating room floor whence all surgical tray setups are dispatched by special lift service to the floor sterilizing rooms below. In this

(*Continued on Page 69.*)

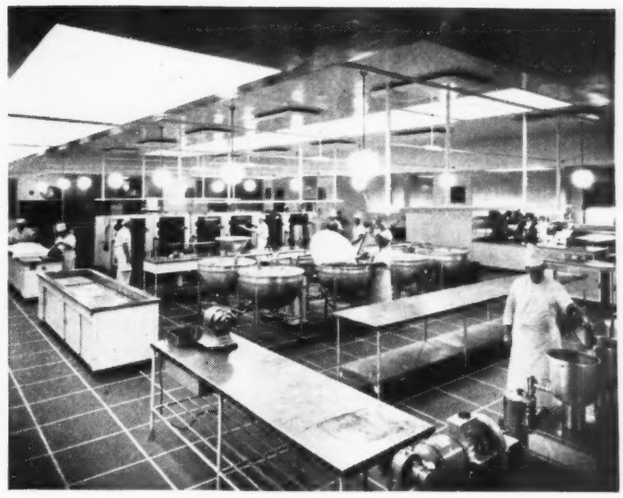
GENERAL VIEW OF THE NURSES' HOME.



TYPICAL BALCONY IN THE MAIN BLOCK.

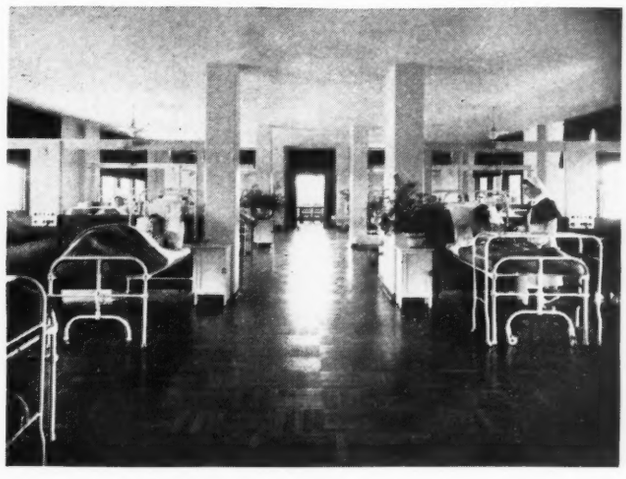


NURSES' WORKROOM, CENTRAL DRESSINGS.

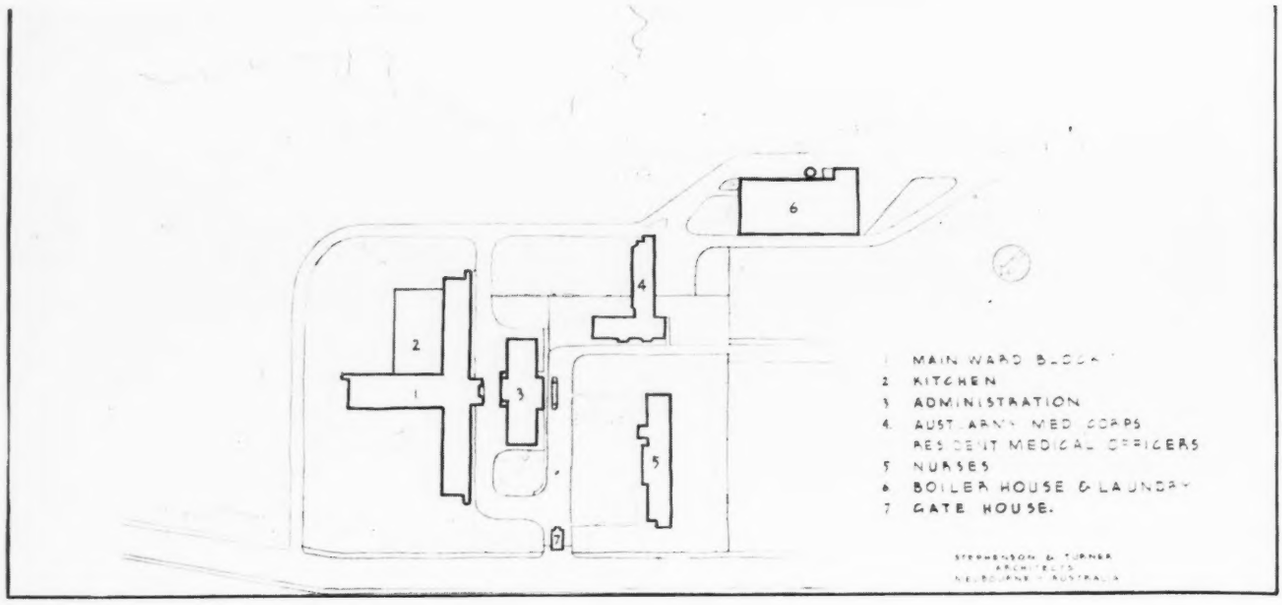


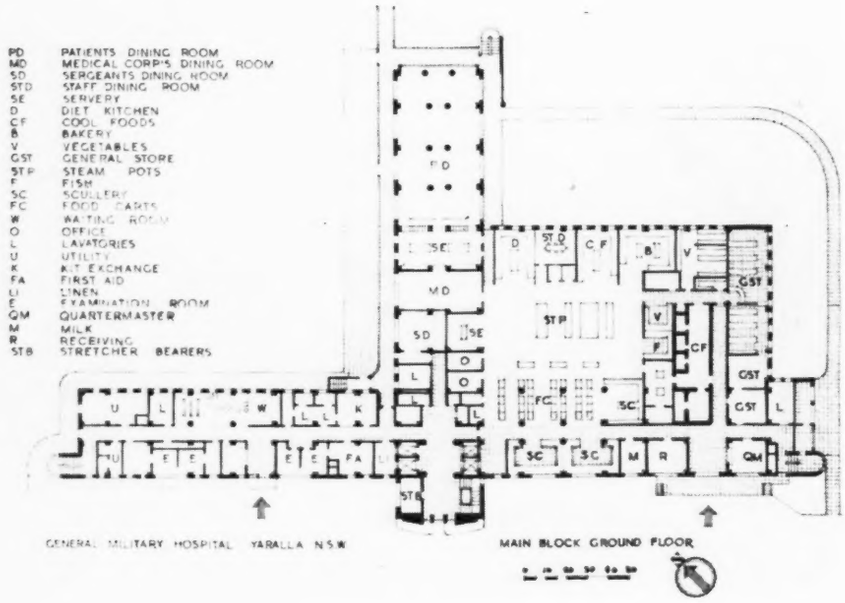
GENERAL VIEW OF KITCHEN IN MAIN BLOCK.

SCRUB-UP LOBBY BETWEEN OPERATING ROOMS.

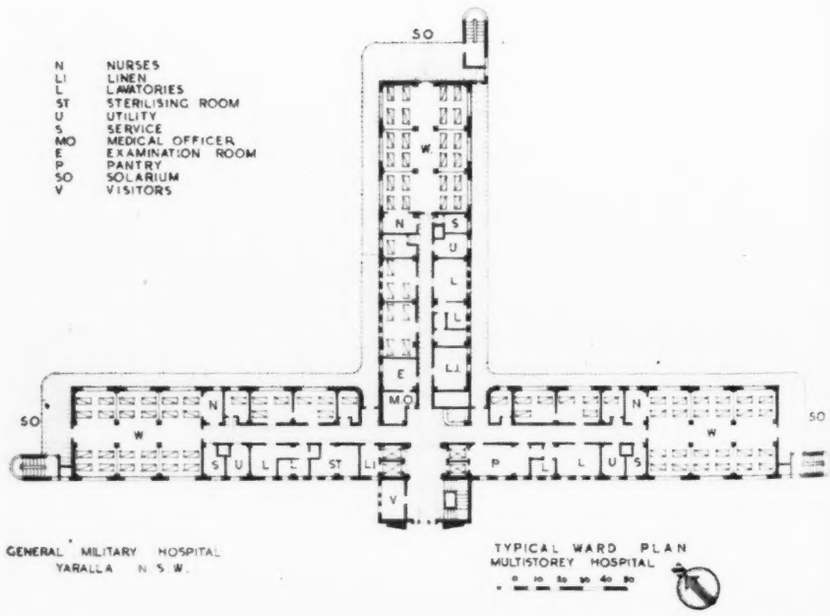


TYPICAL 24-BED WARD IN THE MAIN BLOCK.





Opposite Page, Top: Front elevation of the administration building and main block of Repatriation Hospital. Bottom: General view of the institution from the air.



The three plans which appear on this page show: (top) the general ground plan; (center) ground floor of the main block; (bottom) a typical ward.

hospital special times are strictly adhered to for inspections, dressings, and ward routine duties, giving the greatest freedom to patients and visitors alike.

SOLARIUMS

In hospitals of this nature enclosed solarium space for ambulatory cases is essential. Ample space for this purpose is provided on each floor at the ends of the ward unit. These areas are used for all forms of recreation and for educational purposes as well.

LOCATION

This hospital is beautifully located on the Parramatta River. The trees and shrubs have grown in a profusion of color and shade, and the full meaning of the importance of landscaping and garden layout is apparent and really appreciated.

The Yaralla Military Hospital, as it was generally known, was handed over in its entirety to the military authorities in January 1942. The project was first mooted in June 1940 and the fact that the whole of the plans, the letting of all contracts, and the construction of the hospital itself, with all the associated buildings which cost at that time more than £800,000 Aust., were completed in twenty months shows clearly the spirit which prompted every branch of the building and manufacturing trades in those early days of the war.

PLANNING

In the planning of this hospital, an important point of interest is the separating of the ward unit from the administrative building. When space is available it seems that this method of industrial planning applied to our major hospitals may solve, and has actually solved in this country, many complicated problems.

In certain instances in continental planning the administrative buildings are used for all purposes, such as operating rooms, x-ray department, and outpatients, while the main hospital block is devoted entirely for ward and ward service purposes. We have not gone so far as placing the operating suites in the administrative block but have proved the efficiency of planning the outpatients' dispensary and x-ray departments in this building, with all their associated departments.

When the problems for the care and comfort of the wounded, disabled and sick men and women of our forces were being considered, the government authorities were most sympathetic. They agreed to the provision of the highest quality of materials and equipment available, the sound-deadening of wards and service rooms, and the giving of every facility for nursing and medical care. The extra expenditure incurred has been amply repaid by the appreciation and comfort of the patients, minimum replacement and maintenance costs, and the pride in their hospital of the medical and lay workers alike.

The more experience we accumulate, which unfortunately is gained from mistakes as well as successes, the more I am convinced that there is no cheap way of building hospitals, and nothing in this connection can be a truer summary than, "Whatsoever thy hand findeth to do, do it with thy might."

ST. LUKE'S BUILDS A QUONSET WARD

EARL FINBERG

Building Editor, Duluth Herald, Duluth, Minn.

AT A COST of $1685 per bed, Quonset construction filled in short order an urgent need for additional bed space at St. Luke's Hospital, Duluth, Minn.

Last year the management of St. Luke's faced a common problem: an emergency need for more bed space beyond the hospital's 279 capacity could not be met further by crowding already overloaded rooms and wards. A new building was the only solution, it was decided. St. Luke's had under consideration a major expansion program, the erection of a 141-bed addition. But, because of necessary delays in planning, financing and construction of this $1,500,000 project, it would be about four to six years before relief could come from this quarter.

Some kind of temporary structure was indicated. The hospital's board of directors considered only one possibility — Quonset construction. The suggestion came from a staff physician who had experience with Quonset hospitals during his war service. The former army physician knew that a Quonset shell could be obtained quickly, quickly set up for use, and that it would fill the board's requirement for size.

The members of the board did not need much convincing. They straightway employed Harold St. Clair Starin, Duluth architect, to plan the structure and began to consider a site for the location of a 40 by 100-foot Quonset which would add 31 beds to St. Luke's capacity. Studies showed that the most logical location, dictated by the absence of other suitable ground area adjacent to the main building, was the front lawn!

And there the Quonset was erected on a concrete slab poured over a deep base of gravel to prevent frost heaving. The integrally-colored concrete contains the heating system, prefabricated iron coils fed by a central boiler in the main building.

"Radiant heating was selected," says Architect Starin, "because it is the only practical solution to basementless construction in a climate as severe as northern Minnesota's, and, for reasons of economy, no basement was planned. This system also recommended itself as cleaner and more comfortable. It was quicker because the materials were readily available and cheaper to install under the circumstances."

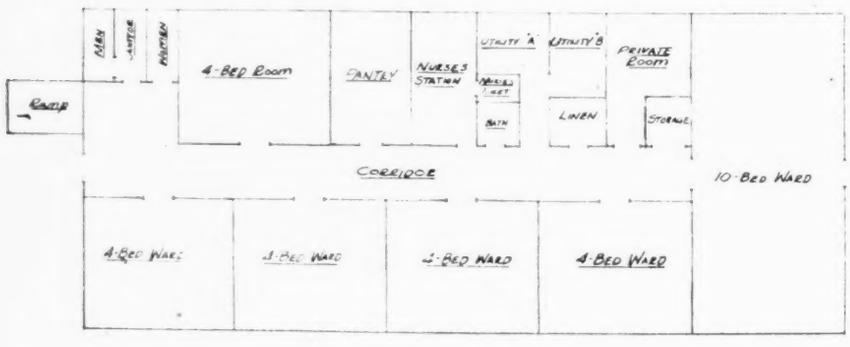
To combat further the rigors of Minnesota winter, 6 inch rock wool insulation was applied to the continuous wall-ceiling surface. Interior partitions are finished in plaster on metal lath. Flat ceiling spans are covered with standard sound-controlling perforated fiberboard panels.

Entry to the addition is from the west end through a short corridor leading from the basement level of the hospital proper. A slightly sloping concrete ramp is the only interior indication that one is entering another building. Ease of access to the elevators was a primary consideration in locating the entry.

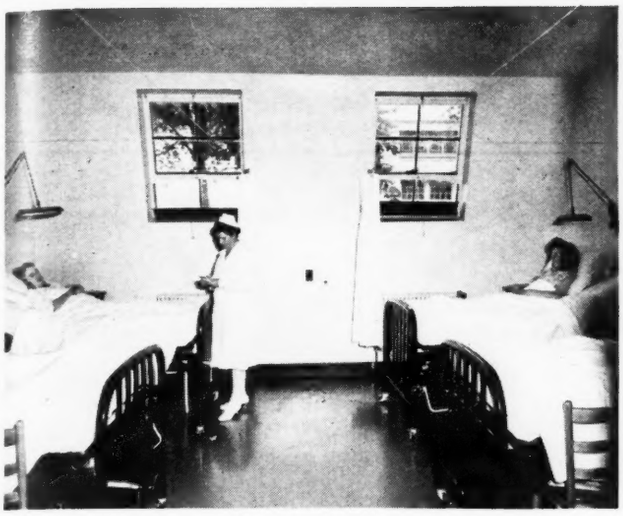
The Quonset is centrally divided down its axis by an 8-foot corridor with emergency exits at either end. Five four-bed wards, a single-bed private room and service areas open off the corridor and a ten-bed ward extends the full width at the east end.

Walls are perpendicular to the floor up to a 5-foot level, where a slight curve starts to bridge the distance to the conventionally flat ceilings. This curve produces the only out-of-the-ordinary feature of the interior, except for higher-than-usual windows. These, incidentally, are advantageous in retaining privacy in a ground level structure situated so close to a public street and sidewalk.

The Quonset addition, according to Richard F. Fox, assistant superintendent of St. Luke's, is "like an additional hospital floor. It is a complete nursing unit in itself," he says, "but no attempt was made to create a self-sufficient hospital. With the exception of sterilizing equipment, no technical hospital facilities were included, because we wanted to use the space for as many beds as possible." A centrally located nurses' station, utility rooms, a serving kitchen, one bathroom, and three toilets are all of the smallest practicable size in keeping with the general idea of affording the most bed space. The single room, says Mr. Fox, is a trifle undersized; the wards provide adequate space for the number of beds in each. He reports complete satisfaction with the fluorescent lighting employed throughout the building.



FLOOR PLAN
Scale 1/8"=1'-0"



ONE OF FIVE FOUR-BED WARDS.

THE QUONSET HUT PERCHES ON THE LAWN.

Construction was begun in the middle of March 1947. By August, the building was substantially completed. "Delays in procurement of short plumbing materials and such vital details as the nurses' signal system were the factors that postponed opening the Quonset for use until October 1," Mr. Fox explains. "Before and even during the construction period we met with some criticism from the public," he reported, "but all objections have melted away since the erection and occupancy of the unit. Patients' reaction, in many instances, might even be described as enthusiastic acceptance."

What patients like best about the Quonset is the quiet that prevails, a natural result of its semi-detached location, away from the hubbub of elevator and corridor traffic, and the efficient and rational use of finishing materials.

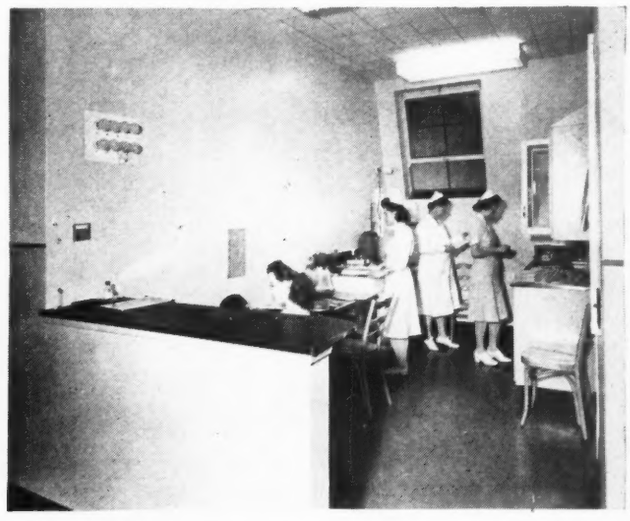
The cost is generally considered reasonable. Total cost of the unit was $52,249.26, which includes the delivered price of the shell, $4,835.27. The cost of its erection was $47,413.99, including the architect's fee. A complete breakdown of costs, according to Mr. Fox, is impossible to make because bills presented by the general contractor included all subcontracts, and in the general haste to get the job done, no attempt was made to separate expenditures for component parts of the building or phases of its erection.

Concerning the cost and the worth of the addition Architect Starin says:

"I was asked to plan an addition to the main hospital that would temporarily solve the problem of overcrowding. The resulting solution added more than 10 per cent of very satisfactory bed space to the institution within a few short months, representing 100 per cent utility and comfort at unusually low cost."

Says Assistant Superintendent Fox: "Because our need was so very urgent, any kind of a solution would have been welcome, and it is particularly gratifying that it could be done so adequately for so little. The unit is full now and has been occupied at capacity since October 1. If it is used to a comparable degree for four years it will have accommodated about 5000 patients as comfortably as if they had been cared for in the main building, and will thus have proved itself well worth its cost."

FOOD IS SERVED FROM THIS KITCHEN.



NURSES' STATION COMMANDS ALL WARDS.

GOOD STAFF MEETINGS MEAN GOOD STAFF WORK

SISTER ANGELICA HOWELL
St. John's Hospital
Lowell, Mass.

BOTH hospital care of the sick and the service rendered to the community involve preventive and curative measures which combine the physical facilities and trained personnel of the hospital. Provision of professional care and the promotion of scientific preventive and curative means can be realized only through teamwork and a spirit of cooperation and loyalty on the part of every staff member. Undoubtedly, the best single method of obtaining the high type of medical interest and service required for both patients and the community is to hold well organized and efficiently planned staff conferences.

The program of the staff conference should include an analysis and discussion of clinical work of the preceding month. Physicians should be frank in their discussions and should properly evaluate their work.

HOW IT'S DONE AT ST. JOHN'S

A brief outline of the staff conferences at St. John's Hospital, Lowell, Mass., will serve as an example of what can be accomplished. They are held on the third Thursday of the month, thereby giving the medical record librarian adequate time to close the records for the month and to assemble the data and complete the analysis sheet. Various committees responsible for the study of infections, deaths and similar matters meet after these charts have been checked by the medical librarian.

The cases selected are then presented to the program committee chairman who appoints the doctors whom he wishes to discuss the cases. The intern usually presents the cases, reads the history and progress notes, and gives the general findings. Various physicians who have been assigned to lead the discussion report the results of their study and research on these cases. An appeal is made to the group for opinions or for additional contributions. A general discussion ensues so that the entire staff has the opportunity of profiting by the study and research of individual members.

On conference day sandwiches and coffee are served at noon and the meeting is called at 12:30 p.m. The business section of the staff holds a brief session previous to the conference which is completed by 1:30 so that the doctors can go to their offices at that hour. This is more successful than holding the conference at 5 p.m. followed by supper at 6 or, another plan, supper at 6:30 with conference from 7 to 8.

The staff conferences are supplemented by grand ward rounds, which have been instituted recently at St. John's Hospital. Before adopting this procedure which had been observed at the Salem Hospital and which was designated as a model setup, five members of the executive committee, with the roentgenologist and pathologist, attended their staff conference and grand ward rounds. Then a special meeting of the staff was called. The secretary presented the Salem program which was approved by the staff.

A chief of each service was appointed and this group in turn called a special meeting of the senior and junior members of the various services. Plans were formulated in detail, each member pledging himself to attend these grand ward rounds. White laboratory coats were purchased to be worn while circulating through the hospital. After the rounds the group retires to the conference room for the discussion of cases. An illuminator has been installed in each conference room to display x-ray films. Discussion and illustration in a friendly tactful manner have proved to be effective in advancing the knowledge of the participants. All knowledge thus obtained is considered as strictly confidential.

There is a secretary for each service who keeps a record of attendance and the minutes so that the results are always available. The surgical chief of service conducts the program which is attended by senior and junior members of the surgical staff, among them the anesthesiologist, roentgenologist and pathologist. Those from the other services who are encouraged to attend have responded enthusiastically. The chiefs of the medical and obstetrical services follow the same program.

Harmony has been promoted among staff members through these conferences and grand ward rounds and the realization of the opportunity for advancement and promotion through participation in discussion and research has been an impetus to younger members to increase their knowledge through reading and graduate study.

CLINIC ATTENDANCE REQUIRED

The proximity of our hospital to the medical centers in metropolitan Boston and the office of the State Medical Society is a valuable aid. A record of the work that is being done is sent out each month and several of our young men attend the clinics one day each week. This has been made a requirement by our staff for advancement to senior membership.

Physicians who have courtesy privileges are invited to our staff conferences and also to participate in the discussions of the grand ward rounds. Courtesy privilege is extended to graduates of substandard schools but under the supervision of the staff. The purpose in this has been to encourage them to advance themselves in medical knowledge and the art of medical practice for the betterment of the care of the sick.

Through staff conferences, doctors returning from the service have been reached, their interest has been enlisted, and their patients have been brought to our hospital. They realize that if a staff is carrying out a daily program of study and research in relation to better medical and surgical care the patients will benefit.

Finally, active educational programs and grand ward rounds lead to better cooperation among the various services of the hospital. The members of the staff know each other more intimately. There is a growing spirit of willingness to share experience and knowledge, with an awareness and appreciation of the achievements and abilities of fellow workers.

GIVE THEM A BOOK ON BABY CARE

Health Education for Maternity Patients Should Start in the Hospital

MARI HIRONS
Chicago

OUT of the more or less subdued clamor of the hospital nursery came a particularly long, piercing, metallic wail. My two roommates, Alice and Jean, and I tensed; we exchanged glances, but we didn't say anything for a moment. We didn't have to. Each of us was wondering,

"Is that *my* baby crying?"

After the wail persisted awhile Jean said she was certain it was her baby, Alice insisted that it must be hers because he cried more, and I threw up my hands and said that no matter whose baby it was I wished they would *do* something for the poor little thing.

Anyone who has ever heard a baby cry has the feeling that he wants to do something about it. Visitors to scientific homes where the "let them cry it out" school prevails sit on the edge of their bridge chairs, trump their partners' aces, and long to dash into the nursery and rescue the baby from whatever unknown terrors he is experiencing.

IS IT HER BABY?

This feeling multiplied about a thousand times perhaps might equal that of the brand new mother who lies in her hospital bed listening to the baby's cry, wondering if it is her baby, realizing there is no way of finding out, and knowing there is nothing she can do about it anyway. Nothing but lie there, and wonder—and worry.

That is the way Alice, Jean and I and countless other first-time mothers all over the country spent those two weeks in the hospital—worrying.

In our particular cases we were convinced the babies weren't nursing well enough and cried because they were hungry. We hoped that they gave them supplementary bottles in the nursery. We asked the nurses about it; they said it was different in each case, and we should ask the doctor.

We had many other questions; we asked them and received answers, but the nurses were in a hurry, and many of the questions seemed stupid, so the answers were hurried, and we were never satisfied.

If we had expected those two weeks in the hospital to be a pleasant fusion of roses, little pink and blue gifts, boxes of candy, pots of flowers, and maternal pride we were certainly disillusioned. True, we managed to meet the obligations of smiles and maternal pride during visiting hours, but the rest of the time we worried. Mostly we worried about going home. What would we do when these tremendous, wonderful little red-skinned bundles of hiccups, glopping eyes, peeling skin, and penetrating screams were thrust at us in two weeks and there would be no authorities on the subject just sitting around the house to tell us what to do next?

That was eight months ago. Now I know more about babies and so do Alice and Jean. But we didn't know anything then, and we needed information more desperately than ever before in our lives.

I know more about hospitals and hospital nurseries than I knew then. I know they are doing everything possible to protect the health of new babies. Every precaution is taken to safeguard them from contagion by the use of aseptic technics, germ-killing ultraviolet lights in nurseries, and many other things.

But eight months ago I didn't know these things, and I sincerely wish that Alice, Jean and I could have been reassured, at a time we needed reassurance most, that our babies were receiving good care.

The nurses were helpful and answered as many questions as possible, but they were busy and in a hurry. All nurses are in a hurry these days because there just aren't enough of them.

When the pediatricians made their morning calls it seemed as if we had a million questions. They answered them patiently, but as soon as they were out of the room one of us would wail that she forgot to ask about such and such and we all discovered that there had been so many questions and so many answers all at once that we couldn't absorb e v e r y t h i n g we'd learned, and had the answers all mixed up so that quandary continued to live in our room.

Many of the questions were so silly that I have since developed an immense sympathy for pediatricians and wonder how they remain so patient and friendly with a host of nearly hysterical women firing silly questions at them all day long.

THEY ALL FEEL THE SAME WAY

I would be inclined to believe that Alice, Jean and I were indeed excessively ignorant if I hadn't recently talked to so many other new mothers who felt the same way, were embarrassed about asking so many questions, but who also experienced this same desperate need for information.

I have talked to girls who had their babies in hospitals in small towns, medium sized cities and large cities and discovered that they all engaged in this frenzied knowledge-seeking activity, and that no hospital, including the very large university teaching hospitals, seems to be doing a great deal about it.

Overcrowded and understaffed, hospitals cannot be expected to provide many special services these days, particularly those which require additional personnel. Because of the shortage of nurses, the upsurging birth rate, and the steadily increasing number of women who are having their babies in hospitals it is not surprising that nurses cannot be spared for the instructions on bathing babies which were provided for new mothers in nearly all hospitals before the war.

However, there is a simple solution to this problem which could easily be provided by each hospital with little or no effort.

Books on baby care placed in Gideon Bible fashion near each bed on the maternity floor would do much to quell the storm of questions. I am sure these books would be appreciated and well used because of our experiment in Room 308.

It all started with the hiccups. Jean's baby persistently hiccuped whenever he was brought in for a feeding. This naturally worried her considerably, and the first few times she asked the nurses about it they were very helpful, showed her how to pat the baby on the back, and so forth. The hiccups persisted. She didn't know whether he hiccuped all day long or just when she saw him. She began bothering the nurses about it and they told her that hiccups really weren't important. Her doctor reported that there was nothing wrong with the baby. Still he hiccuped and no one could comfort her.

BABY BOOK TOLD ALL

Finally I asked my husband to bring our baby book to the hospital because I remembered reading something about hiccups, but couldn't remember what it was. Although I had carefully studied the book before the baby was born my knowledge seemed to have evaporated completely in the midst of the tremendous new experiences of childbirth and hospital routine.

One night after visiting hours I leafed through the book and read the passage on hiccups aloud. It confirmed what the nurses had been telling Jean for days: that almost all babies have hiccups and as a rule "they need cause no concern."

She seemed impressed. "Let me see it," she asked.

I passed the book to her. She read the passage slowly; she read it again and nodded her head. She was convinced. There it was in black and white. She could look at it ten times a day and it would still say the same thing in the same way. Jean was converted—and we heard no more about the hiccups. She patted the baby when he had them, but she was calmer, and her hysterical belief that the hiccups were a symptom of a serious ailment was gone.

It is often just these small things which cause fears and keep new mothers awake at night worrying. They are silly things that don't matter, don't hurt the baby, and are so unimportant that doctors and nurses pass them off lightly and think no more about them. However, the aroused and unsatisfied anxieties are harmful to the new mother, often delay her convalescence, and could easily be avoided through such a simply executed health education program as the purchase and distribution of books on baby care. There are several good booklets on the subject which can be obtained free or at very low cost in cases where the price of books might prove a stumbling block to the program.

Jean on that same night, after satisfying herself about the hiccups, began leafing through the book. She read other things about baby care. Some things she read aloud and answered more of our questions. She studied the illustrations of the correct way to handle a tiny baby, being careful of the head, alternating him from side to side after each feeding so his head will not get out of shape. I nodded. I had read it before. Alice listened intently. They thought it was a wonderful book; they'd never heard of it. I was not surprised because I had looked for it without success at our small town bookstores and had had to order it from the publisher.

Alice wanted the address and so did Jean. They had their husbands send for it right away to have it when they went home.

Alice asked to see the book and read aloud about their eyes not focusing. We were all comforted by the statement that all babies cry at least one full hour a day. Alice's baby cried a great deal, and she positively beamed when she discovered the wonderful little kernel of thought with which all parents must rationalize. Crying is expression. Babies have to let off steam. We talk; they cry—and, best of all, crying is good for the development of the lungs. Alice began thinking about those nice strong lungs little Willie was going to have and forgot her worries.

She leafed through the book and read other things aloud. We began to discuss things like diaper folding and practiced with some hankies.

After that the book was circulating around the room all day long. It worked wonders. Our silly questions stopped. We began asking fewer, more intelligent questions and received intelligent answers from the doctors and nurses who for the first time began to understand what we were talking about.

We seemed to be able to express ourselves better. We learned to sort out our questions and figure out what was general and what was specific about babies. We asked the doctor specific questions about our own babies—now that we had begun to recognize things that actually might be different from the norm. We queried the nurses on things having to do with hospital routine and saved our questions about babies and baby care in general for the book.

Actually the problems do fall into those three categories, and therefore directing questions to the right place is a rather complicated business.

THEN THEY COULD PLAN

Reading the book and anticipating the problems we would meet when we went home helped a great deal to tone down our vague worries. Instead we were able to begin *planning* instead of worrying. The atmosphere of quandary left the room; we were more relaxed and cheerful and began to feel confident that we could do our jobs when the time came.

The little experiment in room 308 worked so well that I can't help believing hospitals would profit in many ways through providing some service of this kind. It would do a great deal to ease the over-protectiveness of the new mother and provide her with information at a time when it will create a more intelligent relationship between her and the doctors and nurses who are doing their best to provide her with the knowledge with which to begin her new job and do it well. These books, placed near each bed, should also be made available for purchase at the hospital by each patient who wishes to take one home. There are a great many books and pamphlets on the subject, but it is surprising how few people know about them and how to obtain them.

The hospital is the logical place for the dispensing of health information.

and on the maternity floor women need to understand something about baby care in order to convalesce properly. Education in child care during those two weeks is nearly as important as hospital and medical care for the new mother. The two go hand in hand. Without self confidence and understanding she cannot properly adjust herself to the big new job of being a mother.

The distribution of books containing general information on baby care would go a long way toward solving the problem. However, the health education program on maternity floors must be two-fold to be entirely effective.

A certain portion of the difficulty arises from the hospital routine itself and therefore seems to require a pamphlet published by each hospital.

STRANGENESS IS INTENSIFIED

Having a baby is a tremendous new experience. Having a baby in a hospital intensifies the strangeness of everything. A particularly difficult problem is created when the hospital intervenes unnaturally in the process of childbirth and separates the mother and baby.

The new mother scarcely sees her baby from the time of its birth until she leaves the hospital except for the short intervals during which the child is brought in for nursing each day. In many hospitals if the mother is not nursing her baby she sees him only once every twenty-four hours. Often babies because of a slight rash which might prove communicable to the other babies in the nursery are isolated completely, and the mother never sees her child again until she goes home.

During all this time in whatever more or less fortunate classification she may belong she lies in bed, wonders how the baby is, wishes she could see him, wishes she could change a diaper—just once for practice. She wishes she could just get a good look at him, get acquainted with her little miracle, but there is really no opportunity.

Of course, much of this would be eliminated by the introduction of rooming-in arrangements whereby the baby is kept in the same room with its mother. This plan has many merits and although it has been introduced in a few hospitals with success the conversion to single rooms and the probable necessity for soundproofing will undoubtedly hinder its acceptance as common practice for many years to come.

So during the time we must continue with the old system of hospital nurseries and mothers who have only fleeting glimpses of their children something must be provided which will assist the new mother in adjusting herself to this abnormal situation as best she can.

A pamphlet published by each hospital which would acquaint the mother with the daily routine in the nursery would do a great deal to convince her that the child is receiving excellent care while she is unable to care for him.

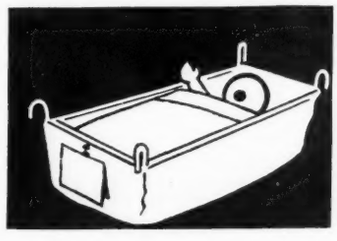
It might contain a "round the clock" story about what is being done for the baby at certain hours of the day so she would know what is happening to him even though she cannot see him.

The pamphlet might describe the special construction of the nursery for minimizing possibility of contagion and the use of aseptic technics and thereby alleviate her personal frustrations with the knowledge that her baby is getting the very best care.

Such a pamphlet would be not only a real service for the patient, but a time-saver for the busy doctors and nurses who understandably do not have much time to answer questions these days, particularly when the same question is asked five or six times as is often the case.

Even persons with above average intelligence will not learn or retain word of mouth information with ease while they are in a hospital, and therefore information written down in black and white and left available for constant reference will do the job better than will word of mouth instruction, no matter how detailed.

This peculiar, though thoroughly understandable, reluctance of the brains to function is particularly ironical at a time when a woman finds she is taking a course in baby care, more concentrated and far more important than anything she ever studied in college—and at a time when she is least able to learn easily.



To add to the difficulties there seems to be no instructor, no lectures, no textbook. There are only catch-as-catch-can answers to a few of the million questions she wants to ask. Even more disturbing, she cannot seem to remember everything she learns, and the spoken word seems to die in the air before in penetrates the brain.

No one needs to know and wants to learn more than does the new mother. The two weeks she spends in the hospital provide an ideal time for learning about baby care. They could be spent *learning* and *planning* instead of worrying as is the case with all the first-time mothers with whom I have talked.

The feeling on this subject among my friends is unanimous. When I reported that there were no lectures on baby bathing in the small town hospital where I had my baby a friend who was to have her baby in another month was quite certain that such instructions were provided at the large city hospital to which she was going.

NO INSTRUCTIONS WHATEVER

After she had had her baby she was as distraught about the situation as I had been. There had been no instructions whatever, I had been absolutely right that no matter how well your mind had been trained through higher education you still couldn't learn much or remember anything. The nurses in her hospital, too, were helpful and friendly, but when she asked the same questions again and again they naturally became impatient with her and she didn't blame them. She thanked me that day for telling her about the books. She had taken hers to the hospital with her, and it helped a great deal.

At bridge parties and showers in my medium-sized-city home town last summer I questioned other girls with new babies and found that they, too, felt the need for something in the way of health education and had spent their two weeks doing practically nothing but worrying.

One of the girls had been a nurse before she was married, and when I described the Gideon Bible fashion of book distribution and possible contents and functions of the orientation pamphlet she nodded her head and said,

"That's really an awfully good idea. I wonder why somebody hasn't done something about it before. When I was working I just thought that bar-

rage of questions was something nurses had to put up with, but when I had my baby I began to understand how you girls feel. In fact I was so comforted by knowing all about the hospital routine I kept thanking my lucky stars I was a nurse, but I thought often during those two weeks and since then how awful it must be for people who don't know what it's all about."

Janet. another of the girls at the party, who belongs to a hospital auxiliary, promised to propose that her group do something about the project. She wrote me recently that the idea was enthusiastically accepted, and it is on the list as next year's project.

While we were discussing it someone mentioned a girl with whom we had gone to school who was in the hospital with pneumonia which everyone thought had been caused because she came home and assumed responsibility for the baby too soon—simply because she didn't want to lie there in bed any longer and worry about things.

They all agreed with me that the physical so-called ordeal of having the baby is never as bad as waking up to the imminent responsibility for the welfare of the tiny little thing, and the terrible feeling of inadequacy.

In the face of all this it is clear that in spite of all the books and pamphlets which have been written about baby care there is still not enough being done to alleviate the anxieties which draw dark circles around the eyes of new mothers and cause the new proud papas to snap at their business associates five minutes after they have handed out the traditional cigars.

All the books and pamphlets in existence will not do a particle of good unless they are properly distributed. Placing good books on baby care beside each bed on the maternity floor, and publishing an orientation pamphlet to be distributed in the same manner is really a simple solution.

Such a program sponsored by the hospital, its auxiliaries or by local health agencies might be the first step in a long range program through which hospitals will take more active part in community affairs. Through this step forward we may see the day when meetings will be held in hospitals; possibly the health agencies will be housed there; the day when the hospital will no longer be the dreaded mecca of trouble and illness, but the center from which all community health activities will stem.

Not the least among these activities is health education. But before health education programs can extend from the hospital into the community, the problem of providing health information where it is needed within the hospital must be solved.

For most of the other patients in the hospital health education is neither necessary or particularly desirable; for patients on the maternity floor information about child care and hospital routine as it affects the relationship between a mother and her baby is essential.

It is not enough that many good books on child care have been written. We cannot shrug our shoulders and say the job is done, the books are written—all that remains is for people to read them. Most people, a surprising number, do not know the names of the books or how to obtain them. In many, many cases it will be through the hospital that the mother first learns of a book on child care.

It is up to the hospitals, health and social agencies and all persons interested in promoting health education to see that mothers and their new babies get a good start by placing this valuable information *where* it is needed *when* it is needed—and that is *in the hospital.*

REPORT ON BONE BANK

Here at the Hospital for Special Surgery, New York City, we have been interested for a number of years in the possibilities of preserving bone. At the start we were unable to obtain a freezing plant, so we employed chemical treatment of bone with the idea of preserving organic elements and leaving out the inorganic. We subjected the bone first to ether and then washed it out with a salt solution, immersed it in plasma and kept it sterile in that way.

There were several experiments with the bone that worked well, but after seeing the work done with the Eye Bank refrigeration seemed the best method to use. We got the deep freeze unit during the winter of 1946 and since that time have preserved the bone in that manner. This is bone that has generally been removed at operations, for example, in osteotomies or in various types of fusion or in hip operations where bone is removed from the iliac crests. This bone has been cultured at time of removal, placed in a sterile bottle and put in the deep freeze and maintained in temperatures of from —10° F. to —20° F. The only other precautions taken are to make sure that the patient had a negative Wassermann and no history of malaria and, in view of the transmission of infectious hepatitis through plasma, to investigate the history of recent attacks of acute hepatitis.

Sometimes prior to operation where there has been no opportunity to defrost the bone, it is found that use of bone in frozen state makes no difference. Blood grouping and typing have been disregarded, although Inclan thought them important. A record is kept of all bone put in the bank—source, diagnosis of patient from whom it was removed and purpose for which it was used—for purposes of complete follow-up.

The Bone Bank has been well stocked, and it is ideal to obtain bone from amputated legs. No bone is taken from legs amputated for malignant tumors, although we feel there is really no danger. Thus far no massive grafts of any kind have been used, although at present we have enough bone, obtained from amputated legs, to permit us to use it for massive grafts when necessary.

Preserved bone has been used in more than 50 cases and so far as we can see the result has been as good as with use of autogencus bone. We have not had a single case in which the graft has sloughed. Grafts have been used mostly in bone defects, such as bone cyst, osteitis fibrosa cystica, fibrous dysplasia. Bone has been used particularly in spine fusions. There have been no infections and certainly no instances of sloughing, although bone has been preserved for as long as ninety days. This proves it is well tolerated by the body tissue.—PHILIP D. WILSON, M. D.

DON'T LET THE SOCIAL WORKER'S SERVICES GO TO WASTE

Her function is to be an interpreter between patient and doctor, hospital and community—not a glorified clerk

CAROL H. COOLEY
Chief, Social Service Department
Presbyterian Hospital, Chicago

IN ITS integration of medical and social services, the social service department has a unique contribution to make to the care of the patient. Maximum value from its activities is possible only when its functions are thoroughly understood. Lack of understanding and consequent misuse or inadequate use of this department lead to deprivation of the patient, doctor, and hospital of professional services which are designed to further the efficacy of care. Because of their nature, its activities are effective only when integrated into the total plan for care of the patient, making a sound program of medical social services dependent upon the understanding and use of this department by the medical staff.

CONTRIBUTION INTERPRETED

At Presbyterian Hospital in Chicago, an attempt has been made to interpret the contribution which the social service department can make to the care of the patient. Of course, this is done informally every day, as members of the department have contacts with the doctors. However, a need was felt for a specific program. The president of the medical staff annually appoints four members to act as a social service committee. This committee has stated that one of its purposes is education of the rest of the medical staff on the use of the social service department. This has been carried on in three ways. The chairman of the committee reports regularly to the total staff. All members of the committee, and particularly the chairman, discuss the department informally with other members. At the suggestion of the hospital administrator, a letter outlining the areas in which the department functions was sent to all members of the medical staff, over the signatures of the committee.

In reviewing the points covered in this outline of function, it should be kept in mind that it was directed to the medical staff. Therefore, the emphasis is on the social worker's contribution to the doctor's plan of medical care and the importance of his request for the service. There is no mention of other activities which might be of interest to the hospital administration. Only the main points of the statement will be given verbatim here. In the letter, each of these was expanded by a brief list of suggested ways in which the worker might accomplish that particular function.

The letter stated:

"Areas in which the social worker is prepared to serve, at the doctor's request, are as follows:

"1. Obtain social information of value in diagnosis and/or treatment.

"2. Facilitate medical care.

"3. Improve understanding and adjustment of the patient and family to illness and its limitations.

"4. Make convalescence more efficacious.

"5. Prevent social problems from developing as a result of illness."

In all interpretation of the social worker's function, it is important to point out that she helps the patient to help himself. She does not tell him what to do, order his emotional reactions, or organize his household. She does help him to understand his interrelated medical-social problems, what choices he has, how his feelings and those of his family are significant, and what community facilities are available to him. Then, she helps him use his own emotional, physical, financial, family and community assets to best advantage.

The social worker obviously must be skilled in meeting the most complex crises which may occur when people who are ill have other related problems. She must know how to help, in order that her assistance may increase the patient's use of his own powers, without taxing him unduly when he is ill. She must have a thorough knowledge of the social causes and results of illness, the social implications of various diagnoses, personality development and behavior, the interrelationships between illness and emotions in psychosomatic illness, and community facilities.

USEFUL FOR ALL ILL PERSONS

This knowledge and skill she brings to the medical team where she can use them best only when they are understood and accepted by the doctor. They are useful for all ill persons, whether private or nonprivate patients, and should be available for any patient when the doctor requests them.

Each of the five functions outlined involves various aspects of the art of helping the patient to help himself, and some explanation of these makes

the statement of function more meaningful. When the doctor requests a social history, which he hopes to find useful in establishing or explaining the diagnosis or which he believes may influence the plan of treatment, the social worker must obtain data covering many aspects of the patient's life. She then selects the information which seems pertinent to the medical situation and presents it to the doctor. In order to determine what is significant, she may have to explore many areas.

The patient's home setting and family relationships are highly important, particularly attitudes toward the patient and his illness, the relationship of the family group to the community, social problems in the family group, the patient's feeling about other members of the family and their problems, and physical setup of the home. Often the patient has had experiences, especially those related to previous illness in the family, which color his reaction to his own illness or may be causative elements. The patient's background of education, vocational training, occupation, mores and financial status may have meaning in his attitudes toward illness.

The financial situation is not as significant in actual dollars and cents as it is in what changes illness may bring, what these changes mean to the patient's pride, and how his ability to follow recommendations may be limited. A social history, to have real value, must give a picture of the patient as a person, his plans, hopes and anticipations, as well as his worries and fears. The process of obtaining this material requires skill; it may take a long or short time. The worker sifts out what seems useful to the doctor, and they discuss it in relation to the medical situation.

FINDS COMMUNITY RESOURCES

The second function, that of facilitating medical care, is perhaps the one most easily understood but may be limited to its more obvious aspects. Help for the patient in obtaining the physical essentials of medical care, either in his own home or elsewhere, is often requested. Referral to the social worker is frequently made for purposes of helping the patient find and use community resources which best meet his needs.

However, there is another aspect of this function which is equally important and which the social worker is

peculiarly equipped to offer. It is to help the patient accept the diagnosis and recommendations. His feelings may keep him from an emotional acceptance of his illness, even if he accepts it intellectually, or they may interfere with his obtaining the required care. He may completely reject a recommendation, such as urgent surgery. The social worker can often help him modify these attitudes which are blocking medical care.

In her task of improving the understanding and adjustment of the patient and his family to illness and its limitations, the social worker's function again takes her into the areas of helping in manipulating the physical environment and in modifying attitudes. Illness may necessitate many changes in a patient's and his family's way of life. If the employability of a wage earner is affected, the financial picture is changed by more than the added expense of care. The primary breadwinner may be incapacitated, or a wage earner may have to remain at home to give care to another member of the family. A change in financial status, with or without illness, can bring change in social status and relationships.

The limitations of the illness may necessitate new outlets in recreational activities, vocational training, or a modified work schedule, all of which are difficult to accept and attain. Families often need help in facing, as well as arranging for, prolonged illness in the home or in an institution. They may feel guilty about having the patient out of the home, even when care there is impossible. Morbidity may be prolonged if the family either overprotects the patient or minimizes the importance of his illness. The social worker can prevent this by helping the family modify its conception of the illness, accept the limitations, and do something practical about them.

Convalescence is an important period in illness, and the social worker can make it more efficacious in several ways. Again her function is twofold, helping the patient and family to obtain the essentials of convalescent care and helping them make important adjustments. It is necessary for the patient not only to have medication, diet and appliances, but to adjust to the use of those essentials of care which set him apart and make him feel different, conspicuous or inferior. Convalescence should be a period in which independence is regained. To achieve it, the patient may need help in readjusting to his group and his new status in it. Vocational rehabilitation and planned recreation may be indicated to complete the process. Through her activities when he is convalescing, the social worker helps the patient to achieve as complete recovery as is possible.

The social worker has an obligation to try to prevent social problems from developing as a result of illness. She can do this in several ways. She gives the patient and his family an understanding of the social implications of the illness that they may realize the problems with which they may be or actually are confronted. She helps them plan soundly for meeting these problems. Finally, she makes it possible for them to utilize to best advantage the assets which they have. These are not only financial assets but also the strengths within the group in their relationship to one another and the community resources which are available.

OF INTEREST TO ADMINISTRATOR

As all of these functions are directed toward helping the patient make his own best adjustment to illness and toward helping him to receive maximum benefit from medical care, they are of interest to the hospital administrator as well as to the physician. The administrator wishes to see each department contributing its share to the total care of the patient and knows that the job of the social service department cannot be well done unless the medical staff understands it.

If the activities which have been described are to be most helpful to the patient, they must be part of the activity of the whole medical team, coordinated by the doctor. Because he can see certain values to the patient and hospital in having a department of social service, even without this teamwork, the administrator may be tempted to take no responsibility for furthering it.

The more obvious of the values contributed by a social service department to the hospital are as follows. The individualization of the patient, making him feel interest in himself as a person, and giving him a feeling of understanding of the importance of his illness to him makes for a happier patient who is less difficult to handle, gets well faster, and therefore goes home sooner.

When a patient refuses medication, diet, surgery or other recommendations or when he wishes to sign a release from the hospital against medical advice, something is wrong. The difficulty may be within himself, in his home situation, or in the way the recommendation is presented to him. Whatever the cause of his distrust of medical advice, his rejection of it means something to the hospital. The social worker is often able to learn the basis of his attitude and correct it, with consequent acceptance of recommendations on the patient's part.

PLANS FOR POST-HOSPITAL CARE

Assistance in sound planning for post-hospital care usually means discharge as soon as the patient is medically ready. By guiding the patient to community resources which can best meet his needs and helping him to use them to advantage, the social worker can protect the hospital's investment in that patient. The value of extensive medical treatment is lost when a patient returns to unfavorable surroundings where he is unable to follow through on after care.

The significant period of convalescence has been described as one in which the patient "is free to gain." The social worker can assist him in meeting his problems so he is free to gain. In her capacity as a liaison agent between the hospital and community the social worker carries the interest of the hospital in the patient beyond the hospital walls and helps the patient to become again a functioning member of his group.

These services which the social worker gives to the hospital are, of course, indirect ones, for they are first of all services to the patient. In his satisfaction with his care, his acceptance of recommendations, his reestablishment in the community, the hospital has a sound investment in good will and a living example of the quality of its service. If the social service department does clerical chores and carries on activities less well trained personnel could assume, it is a waste of both professional service and finances, for the department will then be unable to give the unique services it alone is equipped to render.

The administrator who wishes to prevent this waste will determine whether or not the department is being utilized to best advantage. If it is not, he may find some such device as the letter described here a useful tool in interpretation, which must be a continuing process in which various methods are employed.

VOLUNTEER ACTIVITIES

Best Sellers

It's not an occupational therapy department but a workroom for the hospital's gift shop that accounts for the whir of sewing machines and the buzz of conversation in one of the rooms at Norwegian American Hospital, Chicago. Many of the items in the hospital's gift shop, which not long ago observed its second anniversary, are made by auxiliary members, who also operate the gift shop. Aprons that are lacy and dainty and aprons that are practical and work-worthy are popular items for sale. Another big seller at the gift shop consists of heat-resistant coffee bottles which the women wind with raffia both to add glamour and to provide for ease in handling.

Most of the proceeds from this gift shop go to the hospital's cancer clinic.

Diminishing Teas

Norwegian American auxiliary leaders have been leaders in Illinois in the craze for "diminishing teas" as a money raising project. For those who may not be acquainted with them, a diminishing tea differs from the endless chain idea by one guest being dropped from each succeeding invitation list.

Mrs. Martin has a tea for eight guests. Each of the eight guests has a tea for seven guests. Each of the 56 women attending these teas invites six guests to tea. This goes on until 40,320 women are having one person for tea. The total number of guests at all the teas is 109,601 and with each guest contributing a dollar to a fund the Norwegian American Hospital expects to have more than $100,000 to contribute toward the $800,000 the hospital is seeking for a new nurses' residence.

Sales Are Booming

Another hospital shop that makes sizable profits from the sale of members' needlework is the shop at Evanston Hospital, Evanston, Ill. Last year handknitted items contributed by eighteen women brought in $894. Then throughout the year thirty-six "regulars" sewed bed jackets, towels, baby garments and the like which cost $366 for materials but retailed for $1743. No wonder the shop netted the hospital $5000 during the year. It was manned by eighty-six saleswomen who gave 1624 hours to the project.

The shop donated an even third of the $15,000 the auxiliary gave Evanston Hospital last year. Almost $5000 of this amount came from gifts to the memorial fund, sums sent in place of flowers to funerals or bereaved families and used to help pay for the hospitalization of patients unable to meet their own expenses.

Evanston's Baby Alumni Fund tripled in size last year. Any gift made to this fund in honor of the birth of a baby is used to improve the equipment of the nursery. Recently the fund paid for two oxygen equipped bassinets for premature infants.

This active auxiliary has pledged $500,000 to the hospital building fund. It has already met one-fifth of its goal.

In Honor of DeLee

The Mother's Aid of the Chicago Lying-in Hospital, organized as a sewing club in 1904 and now with a membership of more than 900 women, has established a professorship in obstetrics at the University of Chicago. Known as the Joseph Bolivar DeLee professorship, one of Dr. DeLee's protégés, Dr. M. Edward Davis, occupies the chair.

THE MERITS OF A RATING PLAN

depend upon the judgment and the skill of those who administer it

DONALD C. EDMONDS

Personnel Director

George Washington University Hospital

Washington, D.C.

IRRESPECTIVE of the buildings, supplies, processes or procedures utilized by any hospital or organization, no one has yet discovered a suitable substitute for the one indispensable element required to accomplish institutional workloads: the human being. This basic fact and the varied treatments and methods of dealing with the individual have been formalized and converted into the management field which is known as "personnel administration."

The field of management of people insofar as their working lives are concerned is in its infancy and is but a part of the broad field of social and sociological relationships about which so many questions are being asked and so few being answered. The scope of government, human welfare and economics, with other challenges, compose the broad landscape of the Twentieth Century Man. And in the subfield devoted entirely to working lives, such programs as the annual wage, welfare funds, unionism, unemployment and retirement compensation, and the conditions and emoluments of positions and employment are problems which are in the process of solution by experimental approaches.

Merit rating of employes has existed since the first institution or corporation was established. When employes are discharged or transferred, when salaries are increased or decreased, when employes are promoted or demoted, a practical merit rating has been executed by the supervisor concerned. The sole question is whether or not merit ratings should be formalized, administered on an impartial and fair basis, and recorded. Experience is weighted on the affirmative side.

MUST BE PART OF THE RECORD

Merit ratings—or efficiency or progress reports or whatever the term used—are valueless as a program unless the ratings are definitely tied in with the personnel administration. Whether it is accomplished annually or semiannually, the merit rating must be recorded and made a part of the employe's personnel folder. The rating must be a basis for salary increases and promotions, transfers and terminations in order to play its full part in equitable administration. Salary increases founded on the policy of the "shoe that squeaks the loudest" should be reduced or eliminated.

It would be an interesting study for most hospitals to analyze individual salary increases for the past year or two years and to determine whether they have been based on performance of duties and have been equitably distributed throughout all hospital departments or whether they have been granted on the basis of requests or complaints, with a minority of the hospital departments receiving the majority of the increases and the lion's share of the available funds.

Individual employes are as fully cognizant of management's policies—whether announced or unannounced—on salary increases and promotions as are the persons who administer those policies, and knowledge of salary increases and the methods used to obtain them circulates cynically and rapidly. While the only genuine cure for poor wage and salary policies is job evaluation, advances within grades, if the wage and salary plan is classified on a grade system, should be based solely on merit rating and individual length of satisfactory service.

There are, of course, several types of merit ratings. There is the ranking system where all employes are ranked numerically from number one to the last number in the department and may be judged and ranked on one or more traits. There is the individual comparison plan whereby each person is compared within the department with the others on factors, traits and points. There is the scale program in which employes are rated in degrees on various characteristics. Finally, there is the check list system under which descriptive terms are checked and point values are given.

ADVANTAGES IN EACH

Each of these systems has its advantages and disadvantages, and careful study on the part of the hospital installing a merit rating program is essential if the proper plan for that particular institution is to be chosen. Of the four systems, however, the scale and check list programs are believed to be the most effective.

One of the obvious disadvantages of the ranking plan is the difficulty in comparing employes in two or more departments that have different employe totals. In a department of six persons, no one could be rated lower than six whereas a department of 20 people might have some excellent employes ranked as low as eight or nine. Another disadvantage is that the numbers follow each other and six is ranked to seven as five to six, whereas the difference might be substantial.

ALEXANDRIA HOSPITAL

Alexandria, Virginia

CONFIDENTIAL — RETURN TO PERSONNEL DIRECTOR WHEN COMPLETED

EMPLOYE MERIT RATING FORM

For six months' period ending (date) .....

NAME ..... AGE .....

POSITION ..... DEPT. .....

DATE OF EMPLOYMENT .....

The following portion of this form must be completed by the employe's immediate supervisor, not by the department head or chief of service unless he or she is the immediate supervisor of the employe's work. In arriving at your rating, compare and judge the employe *only* in relation to other employes in the same classification doing identical or similar work.

How long has employe being rated been under your supervision? .....

CHOOSE DESCRIPTION WHICH MOST CLOSELY PERTAINS TO PERSON BEING RATED

ONE ANSWER PER SECTION (ANSWER ALL QUESTIONS) CHECK PROPER SPACE

A. WORK DRIVE AND INITIATIVE

Energetic and willing worker who is always on top of his work and who anticipates requirements	( ) 4
Reliable worker who keeps busy and maintains steady working pace; rarely leaves work unfinished	( ) 3
Generally steady worker accomplishing normal day's work but who needs occasional suggestions or directions	( ) 2
Irregular worker needing constant supervision and repeated instruction in assigning duties	( ) .5

B. ATTENDANCE AT WORK; HEALTH; DEPENDABILITY

Always on hand and accomplishing full day's work	( ) 4
Rarely absent from work or unable to fulfill complete day's physical requirements	( ) 3
Takes sick leave fairly regularly but not an unusual amount; when on duty generally able to do full day's work	( ) 2
Repeatedly absent from work and unable to handle normal workload	( ) 0

C. TECHNICAL QUALIFICATIONS

Thoroughly experienced in his work and gets excellent results	( ) 5
Very competent in his work; rarely makes avoidable errors	( ) 4
Reasonably satisfactory in his work; occasionally makes avoidable errors	( ) 2.5
Barely meets minimum standards of his position	( ) 1
Ignorant of fundamentals of his position; unskilled and unsatisfactory	( ) 0

D. PERSONAL QUALIFICATIONS

Unusually well mannered, cooperative, and neat in appearance	( ) 4
Cheerful and courteous; gets along well with fellow workers	( ) 3.5
Reasonably courteous and neat; generally cooperative	( ) 2
Uncooperative, discourteous, and slovenly in appearance	( ) 0

(over)

E. INTELLIGENCE AND JUDGMENT

Very intelligent with sound, logical thinking based upon wide experience	( ) 5
Above average in intelligence with usually good judgment	( ) 4
Moderately intelligent with fairly good judgment based upon restricted experience	( ) 2.5
Immature judgment; intelligence below average	( ) .5

F. IF THIS EMPLOYE WERE APPLYING FOR THE POSITION HE (OR SHE) NOW HOLDS, KNOWING WHAT YOU DO ABOUT HIM, WOULD YOU: (Check appropriate space)

Enthusiastically employ him?	( ) 10
Definitely desire him?	( ) 8
Be willing to employ him?	( ) 5
Definitely not employ him?	( ) 0

ANALYSIS: Total employe's score ..... point total

ENTER ADJECTIVE RATING (28-32 is SUPERIOR; 23-27, VERY GOOD; 18-22 is GOOD; 15.5-17 is SATISFACTORY; 13-15 is BELOW MINIMUM STANDARDS; 0-12 is UNSATISFACTORY. A rating of this score requires immediate attention of the Personnel Director.)

..... Adjective rating

Rated by: ..... Position .....

ANSWER THESE QUESTIONS ONLY IF EMPLOYE BEING RATED HAS SUPERVISORY RESPONSIBILITIES: (Circle appropriate word. Total *this section only* on space below.)

	5	4	3	2	0
Ability to organize his work	Superior	Very Good	Good	Sat.	Unsat.
Ability to direct people	Superior	Very Good	Good	Sat.	Unsat.
Ability to train employees	Superior	Very Good	Good	Sat.	Unsat.
Ability to get results	Superior	Very Good	Good	Sat.	Unsat.
Ability to handle responsibility	Superior	Very Good	Good	Sat.	Unsat.

(Adj. rating: 23-25, SUP.; 18-22, VG.; 14-17, G.; 10-13, SAT.; 0-9, UNSAT.)

Point score: ..... Rated by: ..... Position .....

Adjective rtg.: .....

To be completed by chief of service or head of department only:

I agree with this report as rendered with the following exceptions: (If none, state "None") .....

This report has been discussed with employe being rated.

Remarks: .....

(Forward to Personnel Director) ..... Chief of Service or Dept. Head

This merit rating form is of the check list type. Since all such forms are in the experimental stage, each hospital must decide upon the best form for it to use. The check list type arrives at a point and adjective total, but points and adjectives are comparative and relative, not absolute. Merit ratings are guides, not standards.

Of all the factors and traits used in preparing a rating system, such items as quality of work, cooperativeness, dependability, knowledge of work, initiative and judgment appear in practically all forms. Items such as marital status and number of dependents should never be included in a rating form except, possibly, for identification and research purposes along with the name, position, department, length of employment and other identifying information.

Most forms generally weight certain of the factors more than others although, mathematically speaking, the mere weighting of items will have no effect on the final ratios of the employes unless the supervisors utilize the differently weighted questions by discriminate grading. (If one trait has four answers rated as 6, 5, 4, 0, and the other traits have values of 4, 3, 2, 0, a supervisor who uniformly chooses 6 and 3 will not affect the final comparative ratings. The purpose of the weighting is to give the rating official a wider latitude of choice.

In rating supervisory personnel, either additional questions or separate forms should be provided which cover supervisory characteristics. In preparing a rating form it is also well to restrict the number of factors or traits. While a horde of factors to be passed upon and graded makes the rating form appear important, the net results are confusing rather than clarifying.

Whatever the technical aspects of the rating form and the rating program, it is important to remember that a well administered program will succeed regardless of a bad rating form whereas a good rating form will not survive poor administration. In the administration of merit ratings the following points must be observed:

1. The plan must be published and explained. Plans may include all personnel up to the administrator. The purpose of the merit rating system must be completely understood by rating officials and employes, and rating officials as well as employes must further understand that the ratings will play an important part in salary increases, promotions, reductions in force, if required, and all personnel matters.

2. The rating program must be a continuing process, either annually or semiannually. Few plans rate oftener than twice each year.

3. A review of the plan must be held for all rating officials before each rating date. Ratings, of course, must always be accomplished by the person most familiar with the individual's work—the immediate supervisor. Ratings should also be reviewed by the department heads. It is mandatory that rating officials understand the interpretations of the rating factors and further understand that they are to use the official (as explained to them) interpretation of each question or trait and not to substitute their own personal interpretation. Otherwise, uniformity of grading is impossible. The personnel director or, if none exists, the administrator should be in charge of the merit rating system.

4. Personnel employed less than three months should be excluded from the rating inasmuch as a reasonable length of time on the job is necessary

for supervisors to appraise employes properly.

5. The plan should require that the final rating be explained to the employe by the rating official before it is forwarded for file and record. One of the major purposes of the rating system is to provide an opportunity for employe and supervisor to discuss the employe's work on a systematic basis.

The practice followed by some supervisors of arbitrarily discharging an employe after several years of service with the statement that "Your work has been unsatisfactory for the last year" while the employe rightfully and sometimes tearfully proclaims that "You never once informed me that my work was not satisfactory" will thereby be terminated. Training needs and unsatisfactory performance of duties will be made known to both management and employes at specified and regular intervals.

6. Except as discussed by employe and rating official, merit ratings must be confidential.

7. A system of appealing ratings if the employe so desires must be provided. The normal grievance channels can be utilized if a formal grievance program exists.

8. Ratings when accomplished and forwarded for permanent file should be analyzed and charted for future reference.

Hospitals that do not have merit rating systems will do well to understand that the program of merit ratings is not an exact science and that any rating can be attacked on the ground that it is a personal opinion. However, personal opinions govern our daily lives, and employes will be rated in salary, promotional and personnel matters whether or not a formal plan is in existence.

Having examined several thousand merit and efficiency ratings over the past few years, I believe that one rating means nothing but that a series of ratings — a continuing program — will reveal that the more highly qualified individuals receive the higher ratings and the less efficient employes, the lower. The chief fault with all rating systems resides in the failure of rating officials, even though properly instructed, to follow the plan and to rate impartially.

There are "high" raters, those who automatically rate all their employes at the top rating, failing to perceive that this procedure is unjust in that the better individuals receive no more recognition for their services than do the poorer. There are the "low" raters; these believe that George Washington could not achieve the highest rating possible on the rating form. And then there are the raters who reward their friends and discriminate against those they dislike but who always produce a rational reason for so doing.

Some supervisors and department heads give high ratings because they do not have the courage to inform an employe personally that his work is average or unsatisfactory but who, nonetheless, will relay such information on a daily basis to the personnel office. Inasmuch as the purpose of rating systems is to reward the well qualified and conscientious individuals with whatever salary increases or promotions are available and, conversely, to dismiss or reappraise the employes whose work is barely satisfactory or downright unsatisfactory, rating officials must prepare their ratings impartially and with a firm conscience but must then be prepared to support those opinions in the face of employe discontent or rating appeal.

Ratings, if unfairly prepared, will most certainly cause discontent. They will cause dissatisfaction also if weak or inefficient supervisors allow unsatisfactory employes to proceed for months without the slighest oral comment or criticism and then allow the rating to descend like an A-bomb. Merit ratings are a part and just a part of personnel administration but properly administered they are an important tool to employes as well as supervisors. Rating programs require education as a continuing process.

Impartiality and equity of administration are essential to enlightened leadership but the implementation of such impartiality requires programs such as the merit rating system and its full utilization in personnel matters.

Doctor Scheele Heads Public Health

WASHINGTON, D.C.—Dr. Leonard A. Scheele, assistant surgeon general of the United States Public Health Service and director of the National Cancer Institute, was named surgeon general of the Service by President Truman February 12. Dr. Scheele's appointment becomes effective in April. He will succeed Dr. Thomas Parran.

Only 41 years old, Dr. Scheele has been an officer in the Public Health Service since he received his medical degree from Wayne University, Detroit, in 1934. After serving as a quarantine officer in San Francisco and Honolulu and in a county public health department in Maryland, he began specializing in cancer control in 1937, when he was assigned to Memorial Hospital, New York, as a special fellow. In 1939,. he became chief of the National Cancer Control Program.

During the war, Dr. Scheele served with the army in military government units in Sicily and Italy and was in charge of the preventive medicine section for supreme army headquarters in Northwest Europe. In 1946, he returned to the National Cancer Institute as assistant chief. His appointment as assistant surgeon general and director became effective last July.

"Doctor Scheele is one of the outstanding figures in public health in this country," Dr. Parran stated at the time the appointment was announced by Federal Security Administrator Oscar Ewing. "He possesses both the professional and personal qualifications to be a great surgeon general."

Among the many notable achievements of the Public Health Service under Dr. Parran's administration were development of the venereal disease, cancer and tuberculosis control programs, organization of the cadet nurse corps, strengthening of state and local public health services through federal grants-in-aid, development of the National Institute of Health research programs and establishment of the national hospital survey and construction program.

MINIMUM STANDARDS for Chronic Disease Hospitals

of 150 Beds and Over

A. P. MERRILL, M.D.

Superintendent
St. Barnabas Hospital
for Chronic Diseases
New York City

A HUMANITARIAN spirit in which the best care of the patient is always the primary consideration is probably even more important in the chronic disease institution than it is in the general hospital.

This is of particular significance because long-term illness is so costly from the patient's standpoint. Ordinarily, the chronic disease patient has been in and out of several general hospitals so that not only his own funds are exhausted but those of his family and relatives are also. Therefore, the prevailing rates in the chronic disease hospital should be moderate, and there should be a liberal policy with respect to free work.

For example, the minimum rate at the present time at our institution is $25 per week, and the maximum rate, $45 per week. These rates include board, routine nursing, routine medical care, ordinary medications and laundry service. The quoted rates do not include modest departmental charges for laboratory work, x-ray service, physical therapy, or consultation fees of specialists. In the custodial section of the institution, the Braker Memorial Home, the minimum rate is $60 per month, and the maximum, $120 for various commodious accommodations.

The board of managers of the Home for Incurables, operating St. Barnabas Hospital for Chronic Diseases, has always been charitably minded as opposed to a commercial attitude which prevails in many of America's foremost hospitals. To illustrate, it has never been our policy to transfer a patient to a governmental institution because of financial reasons. This is a humanitarian spirit of the highest order as expressed in policies laid down by the board of managers. A tremendous amount of good will has been built up over the years because of this, thus favorably influencing to a substantial extent the endowments of the institution.

Further evidence of the salutary effect of this humanitarian spirit are the legacies left to the institution each year. In other words, a charitable attitude creates good will in the community which returns many times over in terms of community support, enabling institutions to build up large endowment funds which make possible an even more liberal policy with respect to free work. Such a policy and a sincere humanitarian spirit are essential to the successful operation of a chronic disease hospital.

Another vital matter concerns policy of admission and length of stay of patients in chronic disease hospitals. Chronic ailments are of long duration. Those institutions are best serving community needs which have facilities to care for patients with chronic illness for the duration of their existence, whether it is a matter of days, months or years. Some chronic disease institutions insist on discharging their patients elsewhere when the immediate medical interest subsides. These unfortunate patients are thrown out on an unprepared community, and

much of the good work which has been accomplished during the hospital stay is lost because of inadequate later care.

An institution giving fully rounded service to chronic patients should have facilities for acutely ill patients, referred to as Class 1; facilities for patients requiring essentially nursing care under medical supervision, referred to as Class 2, and, finally, segregated facilities for custodial or domiciliary care of patients under medical supervision, or Class 3.

It has been pointed out in a previous article that patients often change from one classification to another, and to care arbitrarily for just one of the three classes, disregarding the other two, ignores the essential social elements of the chronic disease problem and is not satisfactory from the standpoint of a well rounded community program. Therefore, a hospital which assumes the responsibility of caring for patients with chronic illnesses must be prepared to face the problem in its broadest scope from a community standpoint, that is, it should establish facilities for the proper care of patients in any stage of chronic illness, regardless of duration. Otherwise, our chronic disease hospitals will fail singularly.

Finally, it may be well to mention some of the opportunities available to chronic disease hospitals from the standpoints of educational functions, medical developments and progress.

INTERN PROGRAM

The opportunity for intern training should be stressed. An ever increasing amount of medical practice of the future will be concerned with chronic ailments, since modern preventive medicine and public health work, as well as new scientific discoveries, exemplified by sulfa drugs and penicillin, are significantly reducing the mortality resulting from infectious organisms. Thus, the age of the population is increasing, and the control of cancer, heart disease and other degenerative disorders is becoming increasingly important to the health and welfare of the public.

MEDICAL TEACHING

Medical teaching should take due cognizance of this changed emphasis in disease incidence to the end that medical students, interns, residents and practitioners of medicine receive proper instruction in the diagnosis and therapies of chronic degenerative diseases, in both early and advanced stages.

An opportunity should be provided the student of medicine, during both undergraduate and graduate studies, to pursue the realm of chronic and long-term ailments as afforded by the modern hospital for chronic diseases. Ample material is available for both undergraduate and graduate teaching, and affiliation with medical schools might rightly be developed with this goal in mind. As part of the internship, one or two months in a chronic disease hospital will provide valuable experience in dealing with manifestations of far advanced disease, as opposed to early manifestations customarily dealt with in the acute hospital.

RESIDENCY TRAINING PROGRAM

Moreover, various chronic disease hospitals provide opportunity for residency training in the following medical fields: (1) internal medicine and geriatrics; (2) pathology; (3) cardiology; (4) malignant diseases; (5) radiology; (6) physical therapy; (7) tuberculosis; (8) chest surgery; (9) neuropsychiatry; (10) orthopedics; (11) mixed residencies; (12) other specialties, depending upon development of medical and surgical services.

NURSING PROGRAM

An excellent opportunity exists in the chronic disease hospital to develop schools for adequate training of registered practical nurses. The need for practical nurses will be felt to an even greater extent as shortages of graduate nurses increase with the development of the government hospital building program and the growing realization that practical nurses are well equipped to relieve the graduate nurses of less technical duties in connection with bedside care of patients.

RESEARCH

The problem of chronic diseases represents the largest public health challenge of the present day. Heart diseases are the commonest destroyers of mankind, and cancer ranks high as a cause of mortality. A large responsibility for the solution of problems of aging and chronic diseases devolves upon investigators in basic sciences, as well as the physiologist, chemist and physicist, who may be called upon to answer these basic problems before clinical geriatrics can make much further progress.

A unique opportunity is provided in the laboratories of chronic disease hospitals for the investigation and study of chronic diseases, as well as the problem of aging. Considerable hope may be expected in this direction if community resources are focused to meet this growing public health challenge. Endowments will be needed in support of planned research in this field, as well as sponsorship of research fellowships and other investigative projects pertaining to the field of chronic illness.

CHALLENGE OF FUTURE

A challenge and an opportunity face the chronic disease hospital of today in the application of modern scientific and medical discoveries to the field of long-term illness. The success of this effort will depend largely upon the vision and foresight manifested by progressive hospital administration and boards of trustees. Some of the opportunities for development are as follows:

1. Provision of sufficient beds and adequate facilities to meet properly the community problem of chronic disease.
   a. Additional hospital facilities for acute phases of long-term illness.
   b. Additional facilities for those requiring chiefly skilled nursing care under medical supervision.
   c. Additional custodial or domiciliary facilities under medical supervision.
2. Segregation and classification of chronically ill patients into specialized medical services so that treatment and care can be more efficiently rendered. Development of specialized medical services where newer discoveries in medical science warrant such innovations in order to render efficient institutional care. Possibilities in this connection include the development and establishment of:
   a. Endocrine service with application of recent discoveries in this field.
   b. Chest service, particularly with respect to newer concepts of collapse therapy and surgical approach.
   c. Psychiatric department where new concepts of shock therapy can be applied.
   d. Allergy service with special facilities for treatment and care.
   e. Neurosurgery service with application of newer concepts of surgical treatment.
   f. Pediatric service where adequate

treatment can be given to long-term illnesses in children.

g. Orthopedic service where various crippling deformities can be given adequate treatment. Patients with post-poliomyelitis would constitute a substantial number of this group.

h. Cardiac service where the latest skills and knowledge can be applied.

i. Arthritis and rheumatism service with special emphasis on application of recent knowledge.

j. Cancer service where the latest diagnostic and therapeutic facilities, medical and surgical, can be applied.

k. Other services, such as eye, ear, nose and throat, according to needs as they arise for proper care of patients.

1. Rehabilitation and recreation program, applying knowledge derived from treatment of war injuries in World War II.

3. Extension of service to the chronically ill to groups not now receiving adequate attention:

a. Ambulatory chronically ill.

b. Home care for chronically ill.

c. Chronically ill of younger age groups.

d. Chronically ill with low income status.

4. Establishing fellowships for research and graduate study in the field of chronic illness.

5. Development of endowments to support research in various fields of chronic illness.

6. Development of standards of institutional care for the chronically ill comparable to those prevailing for the acutely ill.

7. Development of greater community support for the chronically ill comparable to that prevailing for the acutely ill.

8. Emphasis on preventive measures and hygiene with respect to chronic disease, in an effort to reduce the incidence of long-term illness.

a. Investigation into social and economic factors contributing to chronic illness.

b. Study of dietary and other physiologic factors relating to development of chronic illness.

9. Determination of relationship between voluntary and governmental agencies in caring for chronic disease patients in various socio-economic and disease classifications:

a. Rôle of federal government.

b. Rôle of state governments.

c. Rôle of city-county governments.

d. Rôle of private and voluntary hospitals and agencies.

This is the fourth and final article in a series dealing with minimum standards for chronic disease hospitals.—ED.

TWO LEVELS OF NURSING CARE

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East Boothbay, Maine

"TWO levels of nursing care" is by no means a new thought. The subsidiary worker as a practical nurse, midwife, kind neighbor, relative or friend has been known and loved by communities the country over. Her services have been accepted as a gracious contribution by one who had the desire to do for the sick and a certain amount of skill born of that desire. As the trained attendant, nurse's aide, ward helper or nurse's helper, she has appeared in the hospital field, assisting in the care of the sick and, again, nothing but approbation can be accorded her who, with so little knowledge, has done so much.

But will two levels of nursing care provide more efficient nursing service? I have tried to pay just tribute to the subsidiary worker as she has appeared among us, but when we are facing the future, orchids are out of order unless they are deserved. So may I say frankly if the subsidiary worker is to continue to function in the future as she has in the past, for the most part untaught, without direction, and with no dignity of position in the nursing economy, my answer to this question is "No, emphatically No!"

If, on the other hand, a permanent adjustment and not a temporary expediency is contemplated so that the subsidiary worker, together with the student nurse and the graduate nurse, and all others concerned in the care of the sick, is to be developed as part of a team, well prepared for the position which she is to fill, then I say just as emphatically, "Yes, two levels of nursing care will provide more efficient nursing service!"

It should be borne in mind that in admitting that these two levels would provide more efficient nursing service, disparagement is not being directed at the graduate nurse. She, like every other specialist living in a progressive age, has been evolving, and in this process she must of necessity discard certain duties and responsibilities, having groomed herself for more advanced procedures.

Witness the transition of the past when the graduate nurse, burdened with more nonprofessional duties than professional ones, was divested of the former that they might be handled by the housekeeping department so that she would be free to serve the patient. Is there anyone who would argue that the cleaning, dusting and sweeping are less well done by women who are trained to do them? Or that the nurse's time is not much better spent caring for the patient?

The aspects of the graduate nurse service are again changing. Many new developments in the care of the sick —intravenous injections, daily transfusions, oxygen therapy, and psychosomatic nursing—have again placed the graduate nurse in the embarrassing position of having too much to do.

To dismiss the situation by shouting "nurse shortage" is to dodge the issue. The question should be asked: "Is the graduate overburdened because there are too few of her or because she is rendering services to the patient that some less well prepared person could render as acceptably?"

The situation is serious, serious enough to have closed wings, pavilions,

From a paper presented at the meeting of the Maine Hospital Association, 1947.

floors and even departments in many hospitals. Does it not, then, merit careful study, a review of the patient's needs, a breakaway from the traditional method of allocating nursing duties, and the acceptance of the modern concept of efficiency in which many are engaged, each at his own level, in caring for the patient's needs instead of having all of his varied needs met inadequately by one person?

Yes, two levels of nursing care will provide more efficient nursing service.

Can this transition be accomplished without detriment to the patient's morale?

Will he accept the two levels of nursing care or will he resent the loss of full time graduate service?

This depends upon the thoroughness with which the preparations for this transition are made.

The following steps are outlined as definite musts in the realization of this more efficient nursing service.

1. The second level group must be available, though not necessarily in large numbers. No new occupation immediately creates wide interest. It will take time to promote enthusiasm for this new rôle.

2. A well developed course of training must be ready. Whether the hospital is to have a training school for attendants or whether, as in the case of the small hospital, local practical nurses and other interested persons are going to apply for this work, each second level aspirant should be taught with scrupulous care every detail of her work and should be held, through constant and thorough supervision, to the exact method taught.

3. Specific duties should fill her day. She should not be left to "find something to do, to discover tasks for herself." Such a situation shows decided lack of executive planning on the part of the one in charge. The more subsidiary workers there are, the more nearly perfect must be the organization and assignment of work.

4. Direct assignments should be made for her either as an individual worker or as a nurse's assistant. There should be no doubt as to which rôle she is to play. There should be no opportunity for anyone to impose on her and thus make it impossible for her to accomplish her assignment.

5. Above all else, she should be made to feel the dignity and importance of her position. The pattern of the patient's needs must be completely finished. She must be taught to see that without her this cannot be accomplished. She is essential to the group.

As for the graduate nurse, she must first be thoroughly cognizant of the relationship between the subsidiary worker and herself. She must not feel that she is being displaced. She must understand that some of her former duties have been delegated to this second level worker in order that she, the graduate nurse, may have time to do the more technical services.

Second, all graduate assignments must be beyond or within the subsidiary worker's level. But the graduate's level must not be invaded by the subsidiary worker. In this transition the graduate nurse must be assured of her position. She is and must remain the fact and symbol of nursing service.

Two levels of nursing care are needed to provide more efficient nursing service. This is not the ultimate goal. The ultimate goal is always just ahead. To attain it our minds must be flexible, amenable to change, but we must always cling tenaciously to the underlying purpose, that of serving the patient most and best.

Male Nurse Serves Many Ways

E. VERNON RICH
Superintendent, Laconia Hospital, Laconia, N. H.

HOSPITALS of 100 beds or less that do not have administrative assistants or purchasing agents could readily utilize the services of a male nurse in their organization.

We should immediately define "male nurses" as men who have completed a three year course as professional nursing students, passed state board examinations for nurses, and are registered in the state as registered professional nurses. This meets all legal requirements for dispensing medications, narcotics and alcohol and for performing any hospital function that can be carried out by a graduate nurse.

For more than a year we have had a young man in our organization who is a graduate of Bellevue School of Nursing for Men Nurses, Bellevue General Hospital, New York City.

He has the responsibility for dispensing medications to the various nursing units. Inasmuch as we do no compounding or prescription work in our dispensary, this young man meets all other requirements for the proper handling and charging of medications in the house. He originates all requisitions for purchase of medications and handles all interviews with representatives of pharmaceutical supply houses and a limited number of surgical supply houses.

With the exception of foodstuffs, all purchased material is routed through the hands of this worker and he is responsible for seeing that the purchase records are properly checked off and show receipt of goods.

We utilize this young man's ability as a teacher for some special classes for our student nurse groups and male attendants. These classes include oxygen therapy, use of the respirator and other mechanical surgical equipment employed in the care of the patient.

Although this co-worker is a part of the administrative department and has no supervision of other employes in the institution, he is invited to attend most department head meetings. We have found his suggestions at these meetings valuable because his activities have some connection with all departments in the house. His close contact with the nursing units, laboratory, x-ray and other departments permits him to coordinate some of the existing problems and helps the department heads correct their personnel and operational problems.

We cannot expect these men to work for the same salary paid to a graduate woman nurse with equal training because they are usually married and have family responsibilities and expenses. We have found, however, that with the proper handling and adequate salary these professional men are able to contribute a great deal to the efficiency and workability of our organization.

PEOPLE IN PICTURES

Among the speakers at the Illinois Hospital Association's midwinter meeting were, seated, L. to R.: Leonard Brumage Jr., Everett W. Jones, George Bugbee, Victor S. Lindberg, Dr. Herbert R. Kobes, Dr. F. V. Meriwether. Standing: George Hendrix, B. K. Richardson, W. L. Couch, Rev. Joseph A. George, Leslie Reid, F. R. Ostrander.

Above: Dr. E. Dwight Barnett, Harper Hospital, Detroit, with Rev. George Lewis Smith, president-elect of the Catholic Hospital Association. Below: S. A. Ruskjer, Waverly Hills Sanatorium, Waverly Hills, Ky., and Louis Blair, Cedar Rapids, Ia.

Above, right: Albert Dollof of Torrington, Conn., with Consultant James A. Hamilton and William J. Donnelly, Greenwich, Conn. Left: Karl P. Meister, Chicago and Rev. E. C. McDade, Nebraska association president. Below, right: Carl Wright Sr., greeting past A.H.A. President Donald Smelzer.

Missouri contingent in a huddle: Mrs. Ann Walker, Kansas City executive secretary, Lawrence C. Austin and Mrs. Irene McCabe.

Richard Vanderwarker, Passavant Hospital, Chicago, John V. Connorton, New York, and Richard Weingartner, also of Passavant.

SMALL HOSPITAL FORUM

THESE ADMINISTRATORS LIKE THEIR BOARDS

IN THIS GROUP OF SMALL HOSPITALS, MOST BOARDS ARE RATED "EXCELLENT"; SOME HAVE SUGGESTIONS FOR IMPROVING THE BOARD

THE average small hospital board member is a businessman who spends two hours at a hospital board meeting once a month, is more interested in financial than in operating or professional problems, and is rated "good" to "excellent" by the administrator, who nevertheless wishes he would inform himself better on hospital problems generally and take a closer interest in the institution itself.

These facts emerge from a study of 28 boards of trustees serving small hospitals in various parts of the country. The hospitals range from 25 to 120 beds; they are located for the most part in medium sized cities or small towns, with two suburban and two large city hospitals included. The average number of beds is 71.

FIFTEEN IS AVERAGE

The number of members of the boards of trustees of these hospitals range from one which has only four members up to one which has ninety. The average number of board members is fifteen. Two hospitals in the group have full boards including forty or fifty members, of whom only executive committees of thirteen or fourteen meet regularly and take an interest in the hospital. For purposes of this study, only executive committee members are included in the reports for these hospitals.

Of a total of 423 board members for all these hospitals, 256, or 60 per cent, are classified as businessmen. In individual hospitals, the number of businessmen on the board varies, however, from one case where twenty-one of twenty-four members are in this group to another which has none.

The next largest classification is women members, with 43, or 12 per cent of the whole group. In no case do women predominate on the board. One group of eleven includes five women, two of whom are business women rather than housewives. (In this case, the administrator comments that the business women are "O.K." but he could use "fewer housewives.")

Other groups on these boards include lawyers, with thirty-four of the 423; clergymen, with thirty members; doctors, twenty-two; farmers, fourteen, and government officials, seven. Of the entire group, there is only one newspaper editor, and only one representative of labor. Thirteen of the twenty-eight hospitals have doctor trustees. In one case, three of nine board members are doctors; in another, four of fifteen; in a third, two of four.

Several administrators commented on the membership of their boards. In two cases it is felt that, since the hospital serves patients from a fairly wide area, board members should be selected from the same area instead of only from the immediate hospital community. On the other hand, one administrator whose board is representative of a fairly extensive area, and consequently meets only every other month, wishes the size of the area could be cut down and the frequency of meetings stepped up. "We need a local board," this administrator comments, "and one that is prepared to spend much more time studying the general operation of the hospital."

Another administrator with a businessman-housewife board feels the need for more professional people, and still another, in the same situation, would like a retired medical man and a member of the county government on the board.

Twenty-four of the twenty-eight boards hold meetings once a month. One board meets at six week intervals; one, every other month; one, quarterly, and one, semiannually. The average length of board meetings varies from an hour to, in the case of groups which meet infrequently, five or six hours. There is no close correlation between the length of the meetings and the size of the group.

Of the total board membership of 423 men and women, 288, or 68 per cent, are regularly present at meetings. Generally speaking, the smaller boards enjoy the best attendance. Five of the hospitals report that 100 per cent attendance is routine; the largest of these groups has twelve members. Poorest record is reported by a hospital where only five of sixteen trustees regularly appear at meetings.

ADMINISTRATORS ATTEND MEETINGS

There is only one hospital in this group where the administrator does not attend all meetings of the board of trustees; this is the hospital with the board which consists of a lawyer, two doctors and a woman. In thirteen of the hospitals, department heads and staff members sometimes meet with the board. Usually, it is explained, this is done only occasionally, when the departmental executive is invited to sit in and discuss a particular problem he or she is concerned with. In one instance, however, this is done right along. "I feel that when questions are asked the department head can answer them better than I can," this administrator explains. "I also feel that the board members at one time or another should meet the department heads, and vice versa."

The traditional interest of hospital boards in financial as opposed to operating or professional problems is clearly shown in this group. Of all the time spent by all the board members in the entire group, the administrators' estimates indicate, 45 per cent is devoted to financial considerations; thirty-six per cent of all time is spent with operating problems and only 19 per cent is spent in dealing with matters that are classified as professional.

In individual board groups, the divi-

sion of attention varies widely, but rarely departs from the emphasis on financial matters. In two hospitals, for example, the board takes no notice whatsoever of professional problems; in several this interest is listed as taking 10 or 15 per cent of the board's time. The most interested board devotes one-third of its attention to these professional concerns. On the other hand, interest in financial matters runs from a minimum of 25 per cent in one case to as much as 75 per cent of total time spent. In most cases, interest in operating problems falls somewhere between the other two classifications.

For the most part, trustees of the hospitals surveyed here do not, according to their administrators, interfere in administrative matters but concern themselves properly with board-level problems. Answering a question on this point, only four of the twenty-eight administrators say the board is meddlesome. One of these administrators comments at some length on trustee relations in her hospital. "I feel that board members should study hospital policies more seriously," she states, "and not blindly accept any recommendation made by an individual doctor.

"Destructive criticism is always taken so seriously that it is a struggle for me to make the trustees realize that in spite of deficiencies and the need to improve, we are actually giving above average care and have above average facilities. I feel this is because of trustee membership made up of narrow-minded men, all most conscientious, but in medicine believing in the *Reader's Digest* beyond anything else. Our hospital and medical and nursing professions' public relations and educational programs are inadequate. We need a more positive outlook."

The board of this hospital consists of three businessmen, three lawyers and three doctors.

A much more common fault, apparently, is board indifference to hospital problems. "Wish members would get sufficiently interested to visit hospital often and learn more about operating problems," says one administrator. Another deplores the board's attitude of leaving everything up to the executive committee.

Judging board performance as a whole, however, the entire group has found little to complain about. Sixteen of the administrators rate board performance "excellent," nine say their boards are "good," and only three go as low as "fair" in their estimation of board quality.

Suggestions for changes in the boards of trustees are revealing and range all the way from one which says eloquently, "Retire president—too old," to several which seek some means for increasing board interest and activity. One administrator laid down a terse, five-point program for improving her board, as follows: "(1) Put a woman on executive committee. (2) Remind president that he is only one member of board. (3) Ask board not to answer questions unless they know the answer. (4) Keep board from making promises that cannot be kept to doctors, employes and public. (5) Have smaller board."

Less specifically, other administrators dream of boards that are "more enlightened as to what all hospitals are trying to accomplish," take "more interest in hospital outside of meetings," have "more understanding of hospitals' problems generally," and are "more publicity minded."

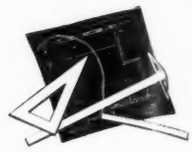
In spite of such wistful comments, it is apparent that most of the trustees of the hospitals studied are serving well enough to keep their administrators reasonably happy.

MEMBERSHIP AND ACTIVITIES OF SMALL HOSPITAL BOARDS

HOSPITAL	BEDS	TOTAL NO. BD. MBRS.	BUSI-NESS MEN	LAW-YERS	WOM-EN	CLER-GY-MEN	DOC-TORS	FARM-ERS	GOVT. OFFLS.	OTH-ERS	NO. BD. MTNGS. PER YEAR	AV. AT-TEN D-ANCE	AV. LNG. OF MTNG. (HRS.)	PCT. TIME TO PROF. PROBS.	PCT. TIME TO OPR. PROBS.	PCT. TIME TO FIN. PROBS.	RAT-ING BY ADM.†
Canada	85	7	3		1		1*		1	2	12	7	1½	25	40	35	E
New Jersey	35	8	3	1	1		2			1	12	7	2½				F
Canada	72	15	5	1		4	4	1			6	10	2				F
California	97	9	3	3			3				12	7	1½	10	20	70	F
Vermont	75	12	9	2			1				12	12	1½				G
Montana	92	13	10	1		2					12	11	1½	33⅓	33⅓	33⅓	E
So. Carolina	76	9	5	1			2			1	12	8	2	20	40	40	E
Oregon	91	10	8	1		1					12	10	1½				E
Maryland	85	11	5	1	3	1				1	12	10	2½	30	30	40	G
Virginia	65	13	9	2		1	1				2	10	6	20	55	25	E
Pennsylvania	36	11	8	1	2						12	11	1½	0	50	50	G
Idaho	50	18	2		2	14					2	16	5	20	30	50	E
California	93	9	4	1	2		1			1	4	7	2	20	40	40	G
Utah	54	14	5	1				6		2	12	8	1½	20	40	40	E
Nebraska	84	9	2	1		1	1	4			12	9	2½	15	40	45	G
Oklahoma	98	13	10	2						1	12	12	1½	10	15	75	G
Wyoming	25	14	6		4	1	2			1	12	8	2½	0	50	50	G
Michigan	40	9	3	1		1			4		12	6	2	33⅓	33⅓	33⅓	E
Ohio	48	7	6	1							12	6	2½	25	25	50	G
Rhode Island	63	90	71	7	8	2	2				9	30	4	25	50	25	E
Illinois	110	4		1	1		2				12	3	1	10	50	40	E
Arkansas	100	15	9	1			1			4	12	10	1	25	30	45	E
Kansas	65	25	19		5					1	12	20	1	10	30	60	E
Minnesota	110	9	6					3			12	7	2½	25	25	50	E
Missouri	65	20	11	2	6	1					12	15	2	25	25	50	E
Wisconsin	35	9	5	1	3						12	8	1	25	50	25	E
Iowa	35	16	8	1	3				2	2	12	5	2½				E
Delaware	120	24	21		2	1					12	15	2	13	33	54	G
TOTAL		423	256	34	43	30	22	14	7	17		288					

*Ex officio member.
†E—Excellent; G—Good; F—Fair.

HOSPITAL PLANNING ROUND TABLE



(*Continued From Page 57*)

in the long run. But I presume there are differences of opinion about that.

MR. SHERMAN: I don't think so. There must be some line to draw as to the size. Seventy-five beds sounds pretty low. It seems to me you have to have enough beds to support your laboratory and x-ray and other facilities. Beyond that I agree with Dr. Smith.

MR. JONES: Of course, two hospitals can split the services of the pathologists and radiologists if they will get together and do it.

MR. SHERMAN: Yes, but they are duplicating the equipment.

MR. BROWN: Is that such a barrier? Of course, the community has so many dollars available theoretically for hospital care, but, actually, when you buy two x-ray outfits, that money was not available to the community if you just had one hospital, because of the urge that causes people to give things. There might be a hundred different motivations, but the chances are that the money would not have been available for health care if the other hospital were not created. So while it is true that you are wasting some of the resources of the community by duplication, you are not subtracting from the total dollars available. If you had all the resources you needed to build a 300-bed hospital, then I say it would be foolish for the same organization to build two. But if you can get money that you couldn't get otherwise to start another hospital, and the community has a need for it, it would be better to start another one. I still believe the old American way is to give a man a choice.

MR. JONES: A little competition.

MR. BROWN: Competition depends on choice. It doesn't mean anything bad to give people a choice.

MR. JONES: I think we should get back into what the architect would like to have, if he could get it, from the planning group.

MR. AYDELOTT: We should like to forget that we know anything at all about hospitals and have someone who likes to think that he knows a lot about hospitals tell us what he knows about hospitals, with particular reference to the job that we are doing. This means that in the analysis of the needs that are in the projected scheme, someone, a consultant or the administrator or the expert, sets up in detail a word picture of what will be expected of this building in the way of function, so that we can analyze it strictly from that point of view.

MR. JONES: So that you have some idea of how many people there will be in the departments, and how many offices?

MR. AYDELOTT: That's exactly the idea. Every fact that bears on the operation of the building. When we do an industrial building, we expect the manufacturer to tell us what machinery he puts in the building, how the product will be processed, who will do the processing, how the hiring and firing of employes will be done, what type of stenographic, secretarial, office help and menial help will be needed. We have a complete picture so that we can analyze it in architectural terms, and when we get the answer on paper we can tell him intelligently why our solution meets his need.

MR. JONES: And you get that regularly from industry?

MR. AYDELOTT: We get it for every type of job except hospitals. That is peculiar. I think something must be wrong with the voluntary hospital system. I don't know what it is, but any system that would result in such a lack of enlightenment among people who are building hospitals, without any more idea about what they are getting into than they have, must be a faulty system. We should like to have the whole picture so that we could back our work up with the assumption that the picture given us in words is correct.

MR. JONES: In an existing hospital, when you are going to develop some new nursing units, or maybe a new dietary department, how important is it to bring in the department heads who are going to operate these new facilities and get their ideas?

MR. BROWN: I don't see how you can escape it. For one thing, there is no better way to build morale than to ask somebody his advice. A hospital that doesn't do this is missing one of the best bets for making the department heads feel they really have a voice in the hospital. To have something built and say "Now, you run it" is just about the most stultifying thing I can imagine.

Also, if you are going to have any development in the science of hospital structure and layout, it's got to come from the people who are using particular sections of the hospital day in and day out. The hospital consultant and the architect have to have access to the department heads. You'd be surprised how you pick up good ideas here and there from student nurses, dietitians and pharmacists.

A third point is that if you're adding to the existing plan, the department head has an inside knowledge into the problem she already faces with the old plant. By giving her a chance to say her bit, you get a good idea of what is wrong and what can be corrected at this time.

DR. SMITH: I agree thoroughly that you have to build up from that point and then present a written statement of what is to be done to the architect. I can't quite agree with Mr. Aydelott, and I don't think he really feels that the whole voluntary system is in error because people aren't as constructive as they might be, or can't formulate their thoughts as well as they should. For many, many years now, in view of the fact that there hasn't been much building, administrators have not crystallized their thoughts, but I think that as they are made to they are going to become more and more adept at it and can finally give over to the architect the complete inventory of what they need and how it should be done.

MR. JONES: What is your actual experience in working on consulting jobs where you are making an addition to an existing hospital? Do they bring in the department heads and make use of their knowledge?

DR. SMITH: In the jobs that I have been on, I insist that we start with the department head and work up. Whether or not the administrator would have done that on his own I can't tell you. He doesn't have to completely take their advice, but surely he ought to get it.

MR. JONES: Now take the new hospital.

MR. AYDELOTT: After all, the new hospital is really the planning problem. A hospital that has already been built has been planned.

DR. SMITH: I think you have another approach in the new hospital. I think it's an absolute necessity that you use the technical brains that there are in the community, and the technical brains, whether they are good, bad or indifferent, are the medical men in the community. The medical men have to be organized, as far as the hospital is concerned, into either a permanent or temporary building committee, and that committee has to take its place with the board of directors, administrator, or consultant and help outline the program presented to the architect. The technicians that a new hospital has to depend on are the physicians in the community.

MR. JONES: What about the hospital administrators and department heads in neighboring communities?

DR. SMITH: I haven't had much experience working with them, and I don't think too much of it.

MR. AYDELOTT: I have had some experience bringing these other hospital people in, and it doesn't work very well.

MR. BROWN: I think, though, that a good hospital consultant will normally have come up through the administrative field and will have access to his old hospitals, or to friends. It is impossible for a man to reach the place where he could qualify as a hospital consultant without knowing many outstanding department heads in the field. I am sure that every department head would be delighted to be consulted as to a particular layout. There hasn't been enough of this calling on each other for information.

MR. AYDELOTT: I am interested in the function of these groups. Now I have heard of the consultant and the administrator and the department heads. I selfishly think that they ought to employ the architect right up there at the beginning so that he will at least be familiar with the processes.

DR. SMITH: I think everyone agrees with that.

MR. AYDELOTT: And also give him a retainer fee, and all the usual amenities of the profession.

MR. JONES: Not carry it on the books for two years.

MR. BROWN: You get an architect to come at his own expense, and you talk with him and you get a whole lot out of him in a day or two while he is trying to come to terms with you. It looks to me like there should be some standard fee, some way in which, at a certain cost, you get the architect in and have a chance to discuss certain basic problems of the construction program so that you can size him up and at the same time not waste a couple days of his time, because he's got to make a living. I wonder—

MR. AYDELOTT: I think that is incorrect, but—

MR. BROWN: Well, what is the answer to that?

MR. AYDELOTT: I have just about come to the conclusion that it is absurd for an architect to go journeying over the country to meet boards of trustees by invitation. We are flooded with them. I have three letters in my office right now that are in effect invitations. I don't know generally on what basis I am invited, but I do know that in the end, if I expect to have any success in getting the commission, I have to be political-wise more than hospital-wise, and generally in a strange community it's pretty difficult to be too political-wise. There is not so much effort on the part of the board of trustees to determine who might be most competent to do the job, but instead who might be best known or who might be best connected with the board.

MR. JONES: Some time ago the American Institute of Architects and the American Hospital Association set out to draw up some standards by which they hoped to qualify architects who were experienced in hospital building. What has happened to that qualification program?

MR. AYDELOTT: There has been an effort recently to generalize the knowledge of hospital planning—to have the secret get out, in other words, and have more architects familiar with hospital planning. Up to a few years ago, there were only six or seven architects in this country who were really active in the hospital field, and perhaps that was an unhealthy situation. Now the American Institute of Architects took the stand that a competent architect is trained to solve a building problem, and that a hospital is, after all, just a building problem, and that any effort made to catalog his abilities would be contrary to the very substance of his professional standards.

However, the American Hospital Association went right on, which I think is a good thing for this reason: It at least makes the architect, particularly the younger architect, aware of the fact that there is such a thing as recognition by an outside lay group, that there is a difference in architectural service, and that it is possible to get a good architect or a bad one. It might not be too bad a thing if it were possible to catalog architects by competency and incompetency, but as long as that is not done, I think it is fine that the hospital field has undertaken for its own good to try to determine whether an architect is competent or not.

MR. JONES: Hasn't some of this planning work been more or less an attempt to standardize design, or at least to disseminate to hospital administrators and architects the work done by the division of hospital facilities of the Public Health Service? Hasn't that tended to get more architects who understand something about the function of a hospital?

MR. AYDELOTT: That's right. I am very loud in my praise of Marshall Shaffer and the work that his unit has done. So little was known by architects generally about hospitals that you find such things as sterilization rooms without any drains in the floor. The man who knew enough to tell the architect to put the sterilizers in didn't know enough to tell him to put the drain in, so he didn't. This work that the Public Health Service has done has at least given the architect the pitch on all the little parts of the average small hospital problem, so that he can work out in his own mind what takes place in a hospital. You have to do this in order to get the hospital across.

MR. BROWN: I wouldn't agree too much with that. While I think Shaffer's work has been good, I think

it is going to end up with too much stereotyped planning. What they should do is leave the actual floor designs and so forth up to the consultants and architects and try to analyze by factors. In other words, they should analyze each service and attempt to bring out the factors that make a good or a bad layout, and then make a check list of every service in a hospital, to be sure that all points are covered, because—

MR. AYDELOTT: I am familiar with the check list that Dr. Goldwater set up. It was published in one of the architectural journals, and to anyone who is not pretty familiar with the whole hospital problem, it would be just so much Greek.

MR. BROWN: Well, that is the real place for the hospital consultant. I don't think he imposes himself at all on the architect, but I do think that for the A.H.A. to attempt to draw up a list of approved hospital architects is not too good. First of all, you have got the grandfather clause to consider—who has done hospitals, who are you going to leave out? Next, you are probably giving architects credit for a lot of the work of the consultant when you say, "This is a good hospital," or "This is a bad one." If you didn't have the same consultant-architect team the next time, you might not get the same good result.

I'd rather see boards and administrators, when they get ready to build, look around and employ a good consultant and a good architect, rather than go to a list and pull the name of a good architect, or rather than simply say that the Public Health Service has developed some good plans. I just don't see a standard plan. I do think that drawing up minimum standards as to what should be in a hospital of 200 beds, and so on, is doing a world of good. But I think that the program of The MODERN HOSPITAL of occasionally running a series of plans showing what has been developed, and of sponsoring contests by architects, is a much better approach than to just say in any hospital, "This sort of a utility room—or this sort of a pharmacy layout would be very good."

MR. AYDELOTT: My reason for having such enthusiasm for Shaffer's work is this: Up to 1941, only a half of one per cent of all the building construction was in hospitals, which means that there were very few hospitals built, which means that architects didn't interest themselves in hospitals. Now, if I had never done a hospital and I had never interned with an architect who had done a hospital, I would be totally ignorant of hospitals, so I would have the problem of doing a world of research in trying to determine how the various units in the hospital function and how they correlated themselves.

So what the Public Health Service did was take the combined thinking of various hospital and medical organizations, and through an intensive amount of research, determined what constituted an acceptable solution to some general problems. Any fair architect can take the work that was evolved from that and immediately get the picture, where he couldn't possibly get the picture in any other manner, so there is no question in the world but that it has done a lot of good. There will be a lot of good hospitals built and used that would never otherwise have been built and used, by virtue of the architects having at their disposal for the first time a group of really good, well worked out, well thought out standards.

MR. JONES: What do you think about the series on the functional design of a hospital, with the flow charts?

MR. AYDELOTT: Excellent.

MR. JONES: It's been running now for some months in The MODERN HOSPITAL. I think that gets at the thing you are interested in, the development of just who goes where and what they do in a hospital, which helps you get the relationship of departments that you have to have to solve a building—

MR. AYDELOTT: Of course, that is the basis on which the standards were drawn.

MR. JONES: That was not just out of the minds of government employes. They had consultants from all over the country, hospital administrators, architects, doctors, nursing organizations—they must have had 150 or 200 people in on the basic research which led up to some of these suggested designs.

MR. AYDELOTT: They did something there that any group of architects, as far as that goes, couldn't afford to do.

DR. SMITH: Obviously, with any set of details there are people who disagree, and there is a possibility of regimentation, but in general I think the work that Shaffer and his group did is really very commendable, because, whether we like it or not, there are going to be plenty of boards who are going to select untrained administrators to run their hospitals—they have in the past and they are going to in the future. The same is going to be true with the building of hospitals. Many boards throughout the country are going to select architects who have had no hospital experience at all, and if they do follow the leads that have been outlined by the Public Health Service they are going to be very greatly helped. Even if they just took those plans as such, they probably would build a very much better building than they would if they had to build it alone without help.

It is also fine in that it is provocative of thought. A number of people around the country have disagreed, and as a result of these disagreements they have made some changes in their thinking, and as it goes along there will be more and more suggestions made, and while we should keep away from regimentation, very definitely, the standards are a pretty good basis upon which you can start, and from there on vary if you desire.

MR. AYDELOTT: Probably the greatest regimentation the architectural profession has ever known was the regimentation of hospital design before the Public Health Service got hold of it. A hospital was just a hospital. You could read the plan from the outside on all of them, and they were all just identical, and no one regimented them. It was because no one was thinking. They did it that way because they did it that way ten years ago.

MR. BROWN: That's the important thing. I am afraid of standard plans, and I think Shaffer should still give us more of the why than the how. If an architect could go and find out the why, without too much research, then I think he would be much further ahead than to just say to the hospital board: "Well, now, here is a formula room approved by the U.S. Public Health Service and by the A.H.A. and by the National League of Nursing, and so on." Instead, he should say, "This is what should be in a formula room and why it should be."

MR. AYDELOTT: They did do that. They said, "If you can think of a better solution, add it," and they are very anxious to have you do that.

MR. BROWN: That's another good

thing. We have at long last been able to collect this information and put it at the disposal of people who seek it.

MR. JONES: Take simply the equipment check lists which were developed this year for The *Hospital Purchasing File*—the presence of that check list will eliminate a lot of oversights in planning the equipment that has to go into a hospital.

MR. AYDELOTT: I'd like to see some sort of organization within the hospital consultant profession that would guarantee a system of service that the architect could depend on, which would not encroach on his prerogatives and would ensure that he gets the information he requires to plan the building. Up to now we certainly do not have that from all the hospital consultants, and I think it is important to get proper cohesion of effort between the architect and consultant.

MR. JONES: Is there a movement on foot now to get the consultants together?

DR. SMITH: Yes, there is. How successful it will be, I don't know. Of course, the function of the consultant generally is to be the consultant to the board. He should, of course, work with the architect, and sometimes he does work as an employe of the architect, but usually he works as an employe of the board, and is responsible to the board and is a part of the board's organization not only in hospital design and planning, but in the administrative functions that go along to make the building complete and carry on afterwards.

MR. AYDELOTT: I'd hate to have a hospital consultant hand me a square plan, for example, and say, "Now this is the way I think nursing units ought to be organized," and have to fight from that angle. You'd be worse off than you would be with a bunch of laymen. The point I want to get across is that the architect wants the information, but if he is going to be the architect, he wants to be the whole architect and not just part of the architect.

MR. SHERMAN: You say the A.H.A. has listed the qualified architects in the hospital field?

MR. AYDELOTT: Yes.

MR. BROWN: All the qualified ones?

MR. AYDELOTT: Yes.

DR. SMITH: Wouldn't you say they have listed architects who have sent in their qualifications?

MR. AYDELOTT: All right. They have listed the architects who they say have qualified—

DR. SMITH: But many architects don't send in their qualifications. They don't care.

MR. SHERMAN: Is it a reliable list as far as it goes?

MR. AYDELOTT: I don't know. I am on the list, but that doesn't mean that I am qualified.

DR. SMITH: I think I'd say that the men on that list are to all intents and purposes qualified, but it isn't all-inclusive.

MR. SHERMAN: But I think that would be very helpful to the trustees in selecting an architect. They are not competent to pass on the individual qualifications of architects, and I think they are entitled to look to some authoritative source to get that information. Is the same thing being done in the consulting field?

DR. SMITH: I don't think so. It is being discussed, but there hasn't been a list, as yet.

MR. JONES: From your standpoint, such a list would be valuable, wouldn't it?

MR. SHERMAN: Very definitely.

MR. AYDELOTT: I have never made a point of being qualified. If a board asks me whether or not I am qualified, I am and I say so. But there are some good architects who aren't qualified, and I couldn't with honesty say that a man who might be considered for a job alongside our office would be less qualified than us just because he's not passed on by the hospital association.

DR. SMITH: He may never have applied.

MR. AYDELOTT: He may have personal scruples against it.

MR. SHERMAN: Even though the list isn't all-inclusive, it still serves the purpose if the proper people are on it.

MR. AYDELOTT: That's right.

MR. SHERMAN: It would seem to me equally important to have the consultants on the same basis. Of course, the board has the final decision to make. At Evanston, we wanted to expand by stages. We figured that we could spend about a million and a quarter on the first part of the program. We called in all the doctors and all the department heads to make suggestions, and when we got the whole thing put together it was about nine million dollars instead of a million and a quarter. Somebody had to make the decision as to what is going to be done, and we have looked to our administrator for much of that decision.

MR. JONES: Of course, your administrator is one of those people who probably would qualify on any list of consultants put out by any national organization—

MR. SHERMAN: Yes.

MR. JONES: —because of his long experience in the field. But a great many hospital administrators wouldn't feel that they were qualified, and they would want help. In fact, it is my experience that some of the ablest people in the field are the quickest to call for help, and some of the least able seem to feel it's a mark against them to have to call for help. The biggest men and the ablest men, in industry as well as the hospital field, are the first ones to say, "We'd like some outside advice to help us clarify our thinking," and often the less able ones are the most resistive to calling in outside help.

ABOUT PEOPLE

Administrators

Dr. Sigmund L. Friedman has been named director of the Mount Sinai Hospital, Cleveland. Dr. Friedman has been director of Sydenham Hospital, New York City, for the last year. Before that, he was assistant director of Beth Israel Hospital, Boston, for three years, and assistant to **Dr. E. M. Bluestone** at Montefiore Hospital, New York, for a year. **Frank Adair,** who has been Dr. Friedman's assistant at Sydenham, was named acting director following announcement of Dr. Friedman's appointment to the Cleveland position.

E. M. Carpenter has been named assistant superintendent and acting superintendent at Fairmont Hospital, San Leandro, Calif., replacing **A. C. Jensen** who died last year. Mr. Carpenter is a graduate of the course in hospital administration at the University of Chicago. Following his administrative internship at Highland-Alameda County Hospital, he was appointed administrative assistant to **Dr. G. Otis Whitecotton,** medical director of the institution.

Rex von Krohn has resigned as assistant administrator of Mount Sinai Hospital, Chicago, to accept the appointment of administrator of Porter Memorial Hospital, Valparaiso, Ind. Mr. von Krohn is a graduate of the school of hospital administration at Northwestern University and had been active in the hospital field on the Pacific Coast for several years prior to coming to Chicago.

Dr. Walter J. Urben, director of the Wisconsin State Public Welfare Department's Mental Hygiene Division since 1942, has been appointed superintendent of Mendota State Hospital, Mendota, Wis.

Haydn M. Deaner began his administrative internship at George F. Geisinger Memorial Hospital, Danville, Pa., on February 2. Mr. Deaner has just completed his academic work in the Northwestern University Course in Hospital Administration.

Sister Brendan, formerly of Sacred Heart Hospital, Spokane, Wash., has been appointed administrator of St. Patrick's Hospital, Missoula, Mont.

Mrs. Gertrude Linn Sawyer returned to her post as administrator of Memorial Hospital, Sedro-Woolley, Wash., after an absence of one year.

Mrs. Ruth Henderson is the new administrator of Skagit General Hospital, Mount Vernon, Wash., replacing **Mrs. Opal C. Darling.**

George G. Dubach has been appointed administrative assistant of University Hospitals of Cleveland, having recently completed his internship at the institution. Mr. Dubach received the degree of master of hospital administration from Northwestern University. Prior to taking his academic work at the university, Mr. Dubach served in the army medical administrative corps for forty-five months and was discharged with the rank of captain.

Mary E. Gelser has been named to succeed **Helena R. Hughes** as head of Memorial Hospital of Chester County, West Chester, Pa. Miss Gelser resigned as superintendent of Brown Memorial Hospital, Conneaut, Ohio, to accept the position. She had also served as superintendent of Union Hospital, Dover, Ohio, for fourteen years, and of St. Joseph's Hospital, St. Joseph, Mich. for two years.

Emily A. MacDonald, superintendent of F. W. Black Community Hospital, Lewistown, Pa., has resigned to accept a similar post at the new Tyler Memorial Hospital, Wyoming County, Pennsylvania.

Daniel C. Merklee, formerly superintendent of Crozer Hospital, Philadelphia, has accepted the position of superintendent of West Side Hospital, York, Pa.

William R. Williams, who has been associated with the University of Illinois for fourteen years, has been appointed assistant administrator of the 485-bed Research and Educational Hospital of the University. He will assist **Supt. John E. Millizen.**

Robert L. Griess, formerly purchasing agent for the Presbyterian and Woman's Hospitals, Pittsburgh, has been named assistant to **Thompson D. McCrossin,** the administrator. Mr. Griess entered the service of Presbyterian in 1934. He spent three years with the army, serving with the air forces. **Virginia Ferris** has been named purchasing agent in Mr. Griess' place.

Jack A. L. Hahn has been appointed administrator of the Memorial Hospital of Fremont, Ohio. Mr. Hahn assumed his duties there after completing requirements for his master's degree in hospital administration at Northwestern University February 1. While at Northwestern, he served as president of the Hospital Club and vice president of Alpha Delta Mu, professional fraternity of hospital administration. He was formerly night superintendent at Wesley Memorial Hospital, Chicago.

Dr. Robert Randall Cadmus has been appointed to the post of assistant director of University Hospitals, Cleveland. Administrative assistant at Presbyterian Hospital, New York, since 1945, Dr. Cadmus took his premedical work at Wooster College, being graduated in 1936. He received his M.D. degree from Columbia University in 1940. Dr. Cadmus succeeds **Dr. Guy W. Brugler,** who recently accepted the directorship of Children's Hospital in Boston.

Sister M. Loretta, O.S.B., has been selected to succeed the late **Sister M. Patricia** as administrator of St. Mary's Hospital, Duluth, Minn. Sister Loretta has been chief medical record librarian at the hospital for several years. She is editor of the *Journal* of the American Association of Medical Record Librarians, of which she was formerly vice president. She is a past president of the Minnesota Association of Medical Record Librarians.

Sister Mary Patricia, for more than twenty years administrator of St. Mary's

(*Continued on Page* 184.)

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ORGANIZATION is the MACHINE of MANAGEMENT

FREDERIC R. VEEDER

Administrative Staff
Barnes Hospital
St. Louis

AS THE operating costs of hospitals increase and the sources of revenue become more difficult to find, the need for a critical analysis of the organization to be administered is of utmost importance. The dependence upon patient income has been increasing steadily until today the patient is expected to finance from 75 to 85 per cent of the costs of operation. There is, of course, a limit beyond which charges to patients cannot rise, and the administration must find other solutions to the financial problem. It is possible, of course, to reduce services or close part of the institution, or even to increase further the burden placed upon the paying patient. But such methods are not always permanent and are not ordinarily popular solutions. Actually, any of these methods should be instituted only as a last resort.

Any institution has one method available which does not incur public disfavor and which may enable it to operate within the budget. This method is the critical analysis of the organizational structure which has been developed to carry out the activities of the hospital.

PRIMARY TASKS

The term "organization" has been defined in many ways, but basically the definitions have one thing in common in that "organization" is the machine of management in its accomplishment of the ends determined by administration. The methods of developing the "machine" and maintaining it are the primary tasks of management. They may be economically achieved by efficient planning and careful supervision, or by costly trial and error methods. Regardless of what approach is used, the organization must be constantly watched and guided for it is not static but continuously in movement. It will progress, grow and maintain a healthy productive aspect, or become a sluggish, cumbersome, costly parasite demanding more and more of those requiring its services. The trustees and administrator who can guide the organization to the efficient and economical fulfillment of its purpose have justified their positions.

Fortunately, the organizational problems of hospitals and business are similar in many respects, and business and industry have developed some theories on organization which can be helpful to the hospital administrator. In the field of business operated for profit, pressures are constantly placed upon the manager, or director, whatever his title may be, to obtain greater economy and efficiency without loss of quality of product. The same pressures are now being applied to hospital trustees and administrators.

The business manager has always been cognizant of the fact that he must be able to meet competition and so is accustomed to being most critical of his own work—his organization. He realizes he must be able to return a profit to his investors. He must maintain a high quality product and the good will of the public at all times.

The hospital administrator, in many instances in the past, has operated on the basis that his was to provide a service of high quality and maintain good relations with the public, and that a budget deficiency at the end of the fiscal period would be met by requesting more gifts or donations. Such objectives were relatively easy to accomplish without the return to the investor being considered. But now the hospital administrator is being confronted with the problem of a return on the investment which is asked by a well informed and slightly critical public.

WHY THEY ARE HIGH

The question as to why hospital costs are high is one which cannot be answered by merely pointing to higher costs for all other services. The public wants to know if the costs are the lowest that can be rendered by an efficient organization without decreasing the quality of service. If the public is not convinced, it will, as in the business field, seek other sources to fulfill its needs.

It is not possible for the hospital to approach the entire problem of costs from a strictly business point of view. It cannot give special bargains to attract the crowd, as in most instances it is operating at capacity. It cannot enter into agreements which will give it any real position of advantage over competitors. It is not suggested that the various policies and methods used to increase profits to a business enterprise be considered. There is much, however, that can be learned from the practice developed by profit enterprises of a critical analysis of the organizational structure, and decreasing over-

head costs by economic and efficient administration.

The administrator is not expected to be competent to perform all of the jobs in his institution, but he must have an understanding of them. However, in considering problems of the organization he is the specialist. No one else is in a position comparable to his, and no one else can have equal authority. He must be capable of recognizing and deciding questions which affect his organization.

It would be impossible to relate here in any detail the method by which the hospital administrator, or trustees, can determine whether or not the organizational structure is the best suited for the individual institution.

The first approach must necessarily involve the use of an organization chart. It is well to prepare one chart representing that which may be considered as an ideal for the organization; the other should be prepared from a realistic point of view showing what the actual structure of the organization is. Far too many administrators develop an organization chart representing the ideal rather than one which actually represents their own organization.

RELATIONSHIP IMPORTANT

Of prime importance is the relationship of the administrator to the board of trustees. The chart should show direct communication to and authority from the board and, certainly, no circumvention of the administrator by the administrative assistants or the department heads. It is well to review carefully this section of the chart and to be factual in determining whether or not there are formal or informal contacts between the board and administrative subordinates.

If informal relationships do exist, the administrator must be aware of the influence which can be exerted by his subordinates. He may find himself in a position where he has a title denoting authority, but such authority is diluted by the individual desires of those subordinate to him. Of course, such a relationship between the administrator and the board is highly unsatisfactory and detrimental to the organization as a whole. Any contacts between subordinates and the board of trustees on matters affecting the organization must be through the administrator if he is to function effectively.

Below the administrator are shown the positions of administrative assistants, if such exist. It has been noted in some instances, particularly in smaller institutions, that no position of assistant administrator is shown on the organization chart. However, a brief discussion with the administrator will often indicate that a department head or one of the employes in the general office is assuming such responsibility without official recognition. This is a most difficult position for the employe who, being of a responsible nature, acts during the administrator's absence rather than have endless delays and confusion.

Positions carrying administrative responsibility and authority should be clearly indicated on the chart. It is unfair and unwise for an administrator not to designate some person officially as acting for him when necessary. To leave such matters to chance is to place the organization in a vulnerable position and can easily lead to inefficient and costly administrative routines. A request of a patient, visitor or vendor which cannot at least be tentatively decided during the administrator's absence certainly does not improve public relations.

Dropping below the administrative level to the departments, the board and the administrator should carefully check the relationship of each to administrative authority. They should know to whom the departments are responsible and from whom the administrative supervision stems. It is well at this time to inquire of each department head as to whom they believe they are administratively responsible. Some of the answers may be most surprising. On occasion the department head may have no idea who is his immediate superior.

There should be clearly understood lines of authority and administrative supervision. If such do not exist, each department will become an entity within itself and strive to strengthen its position in the organizational structure. This develops an unhealthy competition for higher salaries, more employes and fewer hours of work among the departments and places an additional drain upon those providing the revenue. Competition among the departments to improve services, reduce costs, and achieve greater efficiency is desirable, and the organization as a whole will benefit. The self seeking competition is conducive only to individual gain of the employe at the expense of those needing hospital care.

A critical examination of each department through observation and conferences many times will disclose instances of certain factions within the department attempting to establish their own sphere of influence. An ambitious employe may refuse to recognize the department head and go directly to an administrative assistant or the administrator for a decision. If he is recognized, the establishment of a separate department may be well underway. Administrative assistants and administrators too often, without thinking of the results, give opinions and answers to employes which break down the effectiveness of the department head.

MUST HAVE PLANNING

No new departments should be established w i t h o u t administrative planning and decisions. Each new department means additional salary increases, more personnel, and more supplies. If services can be consolidated through planned departmentalization, the economy and efficiency will ordinarily be improved. In reviewing this phase of the chart, the administrator must decide either to recognize any new departments officially or to reestablish effectively the channels of authority. There are times when new departments are necessary, but these should be created through careful planning and decisions on the part of the trustees and administrator —not by the unthinking recognition of an aggressive employe.

Administrative decisions involve finance, directly or indirectly, and there must be supervision to give control and efficient operation. All workers want independence, but economical coordination of effort can only be gained by the organization's functioning as an integrated whole guided by a capable and informed administrator. When all of the lines of the chart are completed, when the relationships of the departments are established and the chain of command has been clearly shown, then the board and administrator must decide if the results are what they want. Once this has been decided, the administrator must be the one who makes any changes in the structure. Continuous review of his organization must be maintained for there are always those who, being interested in their own little sphere of influence, will be in constant motion to improve their position at the expense of others.

MEDICINE AND PHARMACY

Mental and Emotional
PROBLEMS OF ANESTHESIA

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THE anesthetist occupies a strategic position as a pilot through a critical event. Responsibility for safe passage rests on mechanical skill acquired during preliminary training and through practical experience. This is the science of anesthesia which can be mastered with a high degree of accuracy. Proficiency comes from a broader view, an understanding of the mental and emotional relations of the patient. This is the art of anesthesia.

To define the emotions would be difficult, yet everyone understands in a general way the meaning of love, hate, fear and anger. Furthermore, the fact that the emotions affect the function of the body is well known and in recent years great advance has been made in analyzing these relations. The most important emotion related to anesthesia is fear.

PROLONGED FEAR IS HARMFUL

Simple acute fear may be useful; *e.g.* experience teaches one not to touch a hot stove for fear of being burned, not to touch a live wire for fear of shock, and to get out of the way of a falling object. More intense fear becomes fright; *e.g.* experience with a hot stove may cause one to be frightened of all stoves. This reaction is partly useful and partly harmful. Prolonged fear becomes anxiety and is harmful.

Comparison of fear and anxiety may be illustrated by the response to warning about cancer. If the desirability of periodic examination to avoid cancer is mentioned, simple and useful fear causes the individual to be examined, and when told he has no cancer, the thought of it is dropped. Another individual worries about every pain and avoids examination lest he be told that he has cancer. Continued anxiety about cancer causes more and more pain and is harmful. The intensity and duration of fear, therefore, determine whether it is useful or harmful. It is harmful fear or anxiety with which we are now concerned.

Let us now consider some of the fears related to anesthesia.

1. Fear of death is common. It is often difficult to determine whether fear of death refers to the operation or the anesthesia. They are closely related. At least half of the patients going to the operating room entertain the idea that they will never return alive. This is only natural for self-preservation is the most fundamental instinct.

If the opportunity arises to discuss this fear, the patient may be assured that he has 99 per cent chance of returning safely to his room, or that the risk is less than riding in an automobile or less than carrying on ordinary activities in the home.

In this connection it seems important not to let a patient die in the operating room, *i.e.* in an extreme emergency, when there is little chance that any operation will save a patient, every effort should be made to get the patient back to his room. In the popular mind there is much greater horror of death during an operation than of death occurring in bed.

With this thought in mind the foundation for an ugly rumor may be prevented. That fear of operation and anesthesia may be serious cannot be denied. I recall a patient, observed during my intern year, who died of fright. She was to be operated upon for toxic goiter. She came to the operating room and was placed on the table. Just before the anesthesia was started the patient died. In retrospect it seems probable that if she had been properly prepared, the tragedy would not have occurred. It was a lesson long to be remembered and I have seen that experience repeated only once.

2. Fear of choking on the anesthetic is fairly common. There was good reason for this reaction in the days when a large amount of ether was poured into a cone which was then held tightly over the patient's face until he stopped struggling. Memories of such an experience are long retained and reported to interested listeners with many embellishments. It takes a long time for such rumors to be quelled and we still hear an occasional vague reference to those early experiences.

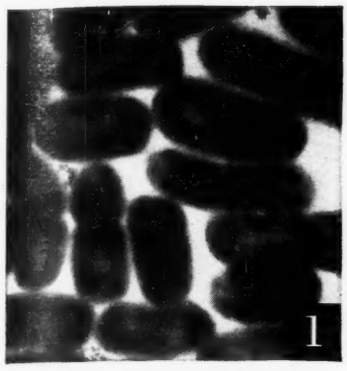
SUCH ACCIDENTS UNLIKELY

Crowding an anesthetic may produce a similar effect, and individuals vary a great deal in their interpretation of crowding. Ample methods have now been developed to take care of choking so a patient may be assured that there is no real danger. The best answer to the fear of choking is a statement that such an accident no longer occurs.

Choking may include swallowing the tongue. Many people believe that swallowing the tongue during anesthesia is a common experience. Since obstruction to the air passages comes at a level of anesthesia when consciousness is lost, belief in such a complication can come only through reports and not from the patient's own experience. Witnesses of anesthesia and postanesthesia recovery should be warned of the danger arising from a casual remark that might be misinterpreted as swallowing the tongue.

Paper presented at the Tri-State Hospital Assembly, 1947.

Double action against K. pneumoniae...with SQUIBB streptomycin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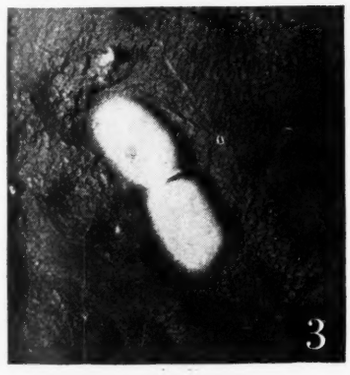
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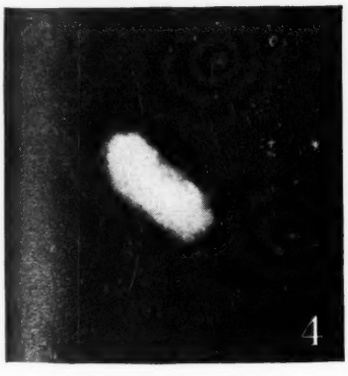
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Micrographs approx. 10,500 X

bacteriostatic action of Squibb Streptomycin against *K. pneumoniæ* is indicated in the accompanying direct transmission electron micrographs.

1. Normal Friedlander's bacillus. Note normally dividing cells in center of picture.

2. Organisms, after 18 hours exposure to Squibb Streptomycin in a concentration of 0.05 mmg. per ml. Cell growth continues, but normal division has been inhibited. Note enormously elongated cell which extends across four or five microscopic fields. Such cells reach a maximum length and die of old age. Note loss of surface definitions in other cells.

bactericidal action of Squibb Streptomycin against *K. pneumoniæ*, occurring simultaneously with the bacteriostatic action, is indicated in these electron microscope pictures of shadowcast specimens.

3. Normal Friedlander's bacillus coated with gold to give relief by the shadowcast technique.

4. Friedlander's bacillus after 18 hours exposure to Squibb Streptomycin in a concentration of 0.05 mmg. per ml. Cell wall shows advanced disintegration. Cytoplasm appears to have erupted through hole in cell wall and to have spread over partially collapsed cell, which is probably dead.

This double antibacterial action — bacteriostatic and bactericidal — against *K. pneumoniæ* was secured with Squibb Streptomycin, a preparation of uniform potency and highest purity. Given in adequate dosage against susceptible organisms Squibb Streptomycin assures maximum therapeutic effect.

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3. Fear of restraint is due to repetition of memories of patients who were strapped to the table before the anesthesia was begun. At one time this restraint was the usual practice. Unfortunately and unnecessarily this procedure is still sometimes used. That patients who are restrained struggle far more than those who are free is well known. Assurance can now be given that the patient will not be unduly restrained.

4. Fear of pain may be presented as a request to "Be sure I am asleep before the operation starts: I cannot bear to think of feeling the knife." To the anesthetist this may seem absurd, but let me relate one experience to show how real the problem may seem. Almost every patient coming from one ward expressed this fear. Investigation revealed that a hysterical girl recovering from operation told everyone near her about her operation. She maintained that she remembered everything and related every detail of her trip to the operating room including, with a high degree of accuracy, all the steps of the operation and the instruments used. Her vivid imagination plus a superficial knowledge of operating technic permitted her to present a plausible story. Repeating this so often she apparently believed it and more or less convinced her listeners. It may be necessary, therefore, to assure some patients that they will feel nothing while under general anesthesia.

AFRAID OF TELLING "SECRETS"

5. Fear of telling secrets has some justification, for partial anesthesia, amytal narcosis and similar procedures have been used by psychiatrists to bring out some things that have been relegated to the subconscious. Periodicals have done much to popularize this idea. It has not been sufficiently emphasized that suggestion is necessary to elicit the response. Response to suggestion should be familiar to all anesthetists. Whether it will be made useful or will be permitted to become harmful may or may not be under control of the anesthetists. An incident will illustrate both effects.

A surgeon preferred "primary ether" whenever possible. This method consisted of inducing relatively deep anesthesia at the time the operation was begun. The patient was then allowed to come out of the anesthesia to a primary level. She would respond to questions when asked. Positive suggestions were made to assure her that she was doing well. An operation for goiter was proceeding satisfactorily until the surgeon asked, "Does it hurt you?" After lapse of a few minutes the patient reiterated, "It hurts me." It was necessary to deepen the anesthesia to block out the effects of suggestion, after which she was allowed to come out to a primary level and the anesthesia proceeded smoothly so long as only helpful suggestions were made. Many similar experiences could be cited.

Some of the remarks a patient makes before anesthesia is begun and during the first part of induction are recalled vividly and accurately at a later time. During the induction the senses are dulled. Sight is lost when the eyes are covered. Taste and smell are no longer appreciated after a few inhalations of the anesthetic. Hearing is retained longer and the perception of sound may be exaggerated. Feeling is the last of the senses to be lost. Inasmuch as mental images depend upon correlation of stimuli from the special senses, disturbing the balance of stimuli may give rise to vague or abnormal impressions. Hence, a quiet room, guarded conversation, elimination of noise, and as little restraint as possible are desirable.

During the recovery from anesthesia the process is reversed; vagueness gradually gives way to clarity. The same caution against permitting unfavorable stimuli avoids confusion and unpleasant memory of abnormal mental impressions.

A recent incident will illustrate: Following a long operation a patient was seen during her recovery. I remarked to her that she had been a good soldier. Later I learned from her family that she thought I had said she was a good soul. In her confusion she thought, "soul—soul—I must be dead for they are talking to me about my soul." The residents who were with me at the time of the visit recalled that the word soldier had been said distinctly. The patient, however, was not in a state to respond normally to stimuli.

Fear of the patient about what he may say is broader than merely giving away secrets. Such a fear is explained by the vague memories of the transitional stages while going under and coming out of the anesthetic. Those who have not had anesthesia may have heard reports from others who have had the experience. What can be done to allay this fear? Conversation and noises can be controlled. Confidence in the anesthetist can be established by her behavior before the anesthesia is begun.

Assurance can be given that the patient is not likely to tell her secrets, and even if she does, they will never be repeated. Spinal anesthesia places an added responsibility on the anesthetists. It is difficult to eliminate noise and conversation during operation. Preliminary sedation may keep the patient at a prolonged, vague state. Helpful suggestions may counteract the influence of unfavorable surroundings.

REQUIRES CONFIDENCE

6. Fear of loss of consciousness is natural and is probably experienced by all to some degree. This fear is related to the most fundamental instinct of life: self-preservation. Possession of all the senses gives a feeling of security. Natural loss of consciousness as in sleep is accepted because one has been accustomed or conditioned to it. Furthermore, the senses are not entirely obliterated for one awakens immediately in response to various stimuli. During anesthesia, however, loss of consciousness is complete. To place one's life in the hands of another is courageous and requires great confidence.

7. Fear of the unknown includes a variety of feelings and is common throughout life, *e.g.* the outcome of a business venture, an examination, or insecurity. Most of the common fears related to anesthesia have been mentioned but now and then some individual fear will be noted which is usually related to some personal experience. Discussion of the common fears gives the patient an opportunity to mention any other causes for worry, which can be answered individually, according to their merits.

Among the emotional relations that might be classed as fear is concern about personal appearance. To deprive a fastidious woman of her cosmetics and finery is no small matter. Substitution with the usual hospital gown is not flattering. Removal of a denture is often a cause for embarrassment. The individual response to these problems is so variable that generalization is not possible, but any comfort the anesthetist may give will be appreciated.

In obstetrics, emotional problems are plentiful but fear of anesthesia is

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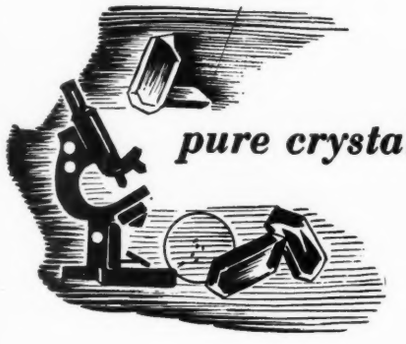

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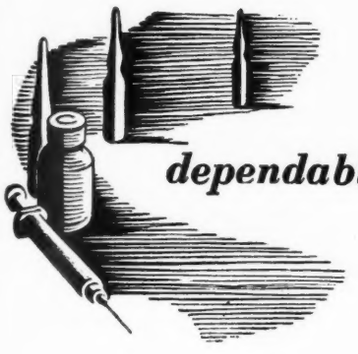

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not prominent. All of the fears already mentioned may occasionally be encountered, but fear of pain is greater in relation to labor than to operation. Anything to relieve pain is welcomed. The obstetrician and the obstetrical nurse thoughtfully consider the relief of pain during labor.

The amount of sedation given before the time of delivery influences the need for anesthesia and the patient's reaction to the anesthetic. The anesthetist should be informed about the emotional nature of the patient and the previous reaction to sedation. Without this cooperation the difficulties of anesthesia are increased.

Fear of choking seldom occurs to the obstetrical patient. On the other hand this presents a real problem for the anesthetist. Interrupted light anesthesia is conducive to vomiting, and when a patient has eaten recently this may be serious and occasionally fatal.

Fear of restraint is expressed more by action than by words. Explanation of the purpose of necessary restraint will help to allay this fear.

Interrupted anesthesia in obstetrics multiplies the chance of an unfavorable response to suggestion. The transition zone of going under and coming out of the anesthetic is repeated many times. Furthermore, while waiting for contraction to recur, it is difficult for the doctor, nurses and anesthetist to refrain from conversation. During this interval the patient is in a more or less confused state and remarks entirely unrelated to her may be assumed to be personal. Too much emphasis cannot be placed on the importance of allowing only helpful suggestions to be made.

Introduction of continuous caudal and spinal anesthesia offers the patient an opportunity to express a preference. Choice of the type of anesthesia should not be left to the patient, for too often the apprehensive individual is the most insistent on using one of the newer methods. It may be fear of loss of consciousness that prompts the choice. This attitude is easily appreciated and deserves consideration.

Reviewing the emotional relations to operation, it is readily seen that the cause for fear of pain has been practically eliminated by the discovery of anesthesia. Other fears have been introduced which can be controlled by sympathetic consideration. The first step in giving relief is recognition of the problem.

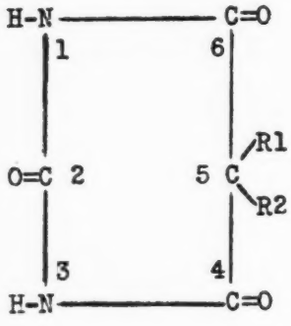
The mechanics of anesthesia have been reasonably well standardized but managing the emotional relations depends largely upon the personality of the anesthetist. Mastering the mechanics is essential to give the anesthetist confidence in herself. It is assumed that the qualified anesthetist is a good mechanic, but the true artist combines with her sympathy understanding and a knowledge of human reaction.

NOTES AND ABSTRACTS

**Prepared by the Committee on Pharmacy and Therapeutics.
University of Illinois College of Medicine, Chicago 12**

THE CLINICAL USE OF BARBITURATES

BARBITURIC acid, although biologically inactive itself, is the nucleus from which many active and useful drugs may be synthesized by substitution of alkyl or aryl radicals in place of the labile hydrogen atoms on carbon atom 5. The barbiturates exert a hypnotic and sedative action by their depression of the cerebrospinal axis. The degree of depression can be from a slight sedative action to a deep coma.



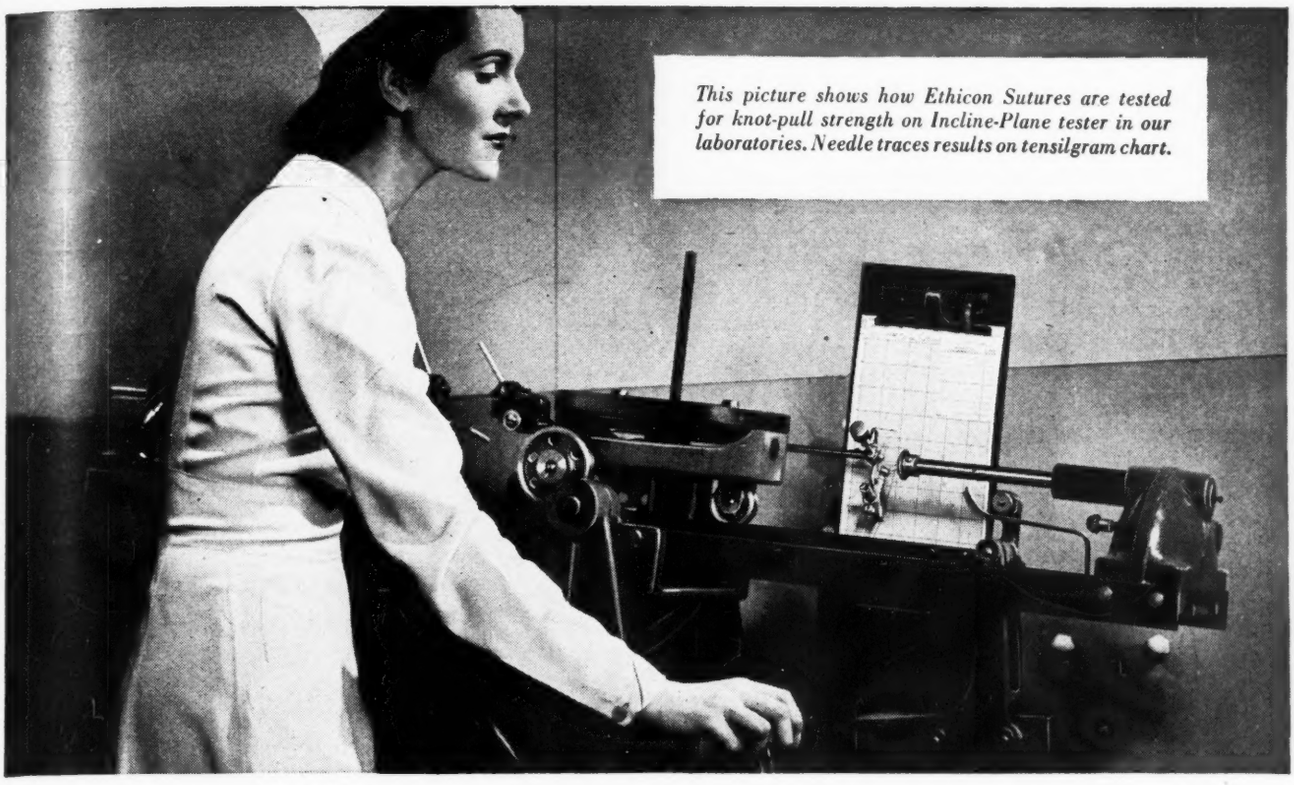
These barbituric acid derivatives can be used for a variety of purposes such as to produce sedation (phenobarbital), to induce sleep (seconal), to depress the motor cortex and thus act as an anticonvulsant (phenobarbital), and to give partial or complete surgical anesthesia (pentothal). The mechanism of their depressant action on the cortex is believed to represent an interference with the enzyme systems which are essential for the metabolism of carbohydrates. An alternate theory suggests that barbiturates are CNS blocking agents acting to block out an essential stimulant metabolite.

Of the hundreds of barbiturates which have been synthesized, approximately eight have been found suitable to be used clinically for their hypnotic and sedative action. Only three of these are listed in the U.S.P. (barbital, phenobarbital and pentobarbital), and the remainder are found in the N.N.R. The various barbiturates differ mainly in their time of onset, duration of depressant action, and in their suitability for use as intravenous anesthetics.

CLASSIFICATION AND STRUCTURE

The barbiturates are classified on the basis of their duration of action in the body. Those derivatives that have radicals on carbon atom 5 which are destroyed easily in the body do not remain active very long and are therefore called short actors. In other cases where the radicals are not destroyed very rapidly, the barbiturate derivatives remain active for a longer period of time and are therefore called long actors.

Increasing the length of the substituted alkyl groups up to 5 or 6 carbon atoms increases the potency and diminishes the duration of action. Branched chains are more easily de-



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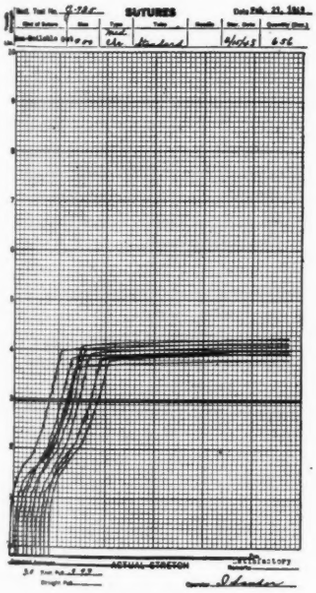
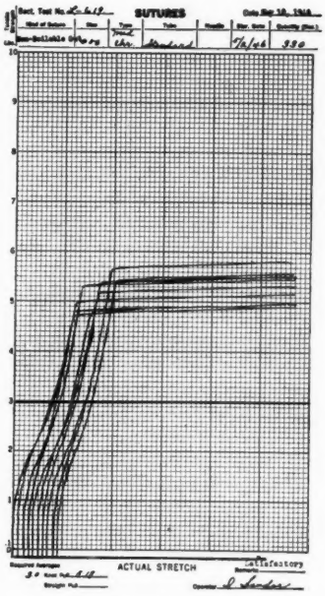


TYPICAL 1945 TENSILGRAM



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SUPERIOR IN THOSE QUALITIES IMPORTANT TO THE SURGEON

Barbiturates Used in Clinics

Action	Drug	Hypnotic Dose (Gms.)	Duration	C-2	Position C-5 (R1)	C-5 (R2)
Long	Phenobarbital (USP) (Luminal)	0.015-0.20	24+ hrs.	....	ethyl	phenyl
Long	Barbital (USP) (Veronal)	0.3 -0.6	12-24 hrs.	....	ethyl	ethyl
Intermediate	Dial	0.1 -0.3	6-10 hrs.	....	allyl	allyl
Intermediate	Neonal	0.05 -0.10	6-10 hrs.	....	ethyl	n-butyl
Short	Amytal	0.1 -0.3	4-8 hrs.	....	ethyl	isoamyl
Short	Pentobarbital (USP)	0.1 -0.2	4-8 hrs.	....	ethyl	1-methyl butyl
Short	Seconal	0.1 -0.3	4-8 hrs.	....	allyl	1-methyl butyl
Ultrashort	Pentothal		¼-2 hrs.	thio	ethyl	1-methyl butyl

graded and therefore shorter acting than are straight chains, and unsaturated short chains are more active and usually shorter acting than are the short saturated radicals. Replacing the oxygen on carbon atom 2 by sulfur gives rise to a series of ultrashort acting drugs known as the thiobarbiturates. The drugs formed by the replacement of the hydrogen atoms on nitrogen 1 or 3 by alkyl groups are of a shorter duration and tend to produce stimulation proportional to the length of the alkyl chain. The drugs become markedly convulsant when both hydrogen atoms are replaced by alkyl radicals.

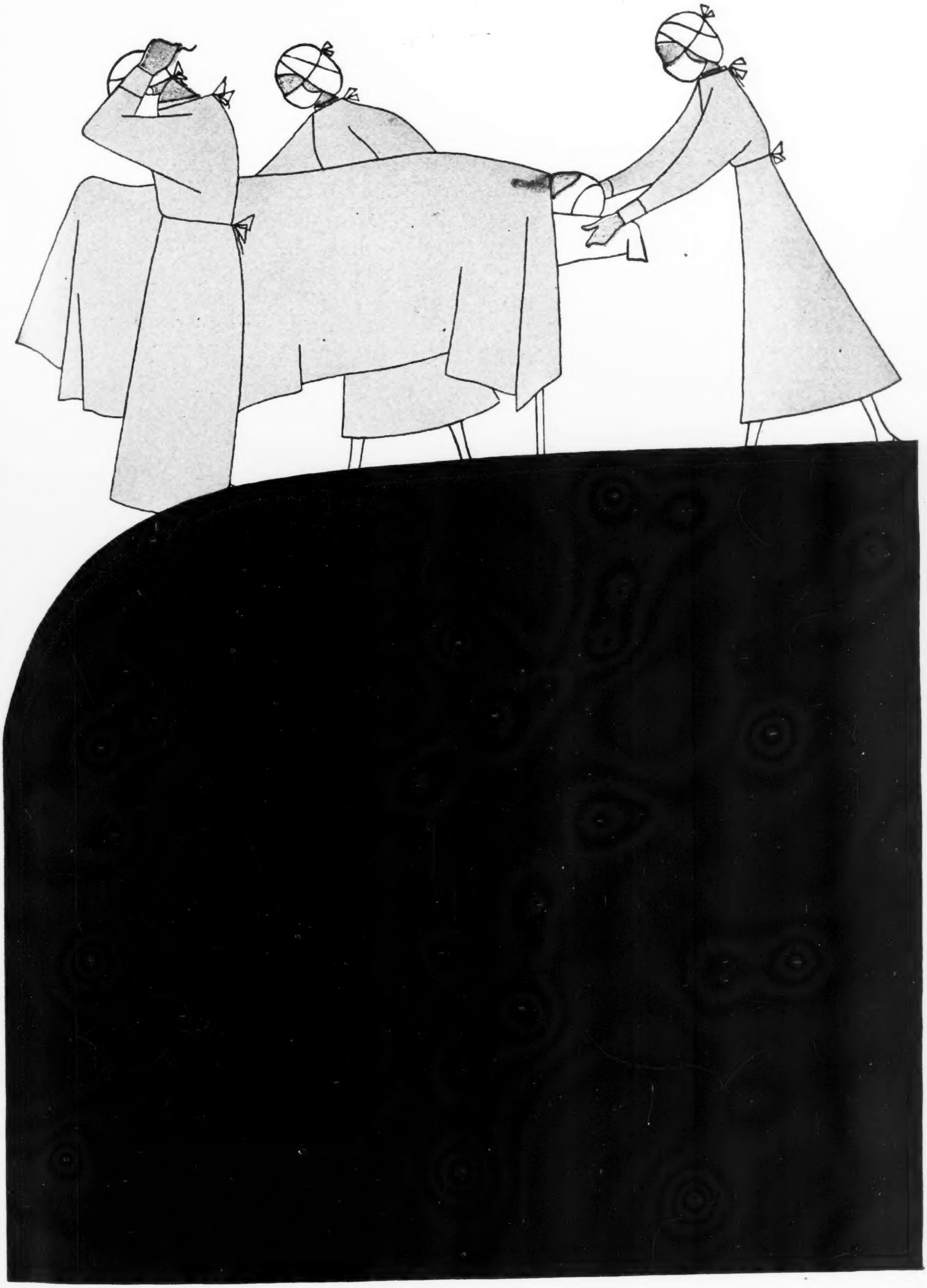
TYPE OF ADMINISTRATION

The acid form of these drugs is stable, alcohol soluble, and insoluble in water, while the alkali salts of these drugs are water soluble but deteriorate rapidly and become increasingly toxic in solution. When aqueous solutions are used they should be freshly prepared. The hypnotic effect of the ultrashort actors is practically nonexistent when given orally because they are destroyed almost as fast as they can be absorbed from the intestinal tract. The latent period between oral administration and observable effects is from ten to fifteen minutes for the short actor, from fifteen to thirty minutes for the intermediate actors, and from thirty to sixty minutes for the long actors.

Intravenous injection should be made slowly with the water-soluble salts (0.5 to 2.5 per cent solution) of the ultrashort or short actors. The total quantity administered should be guided by the signs of anesthesia.

Official U.S.P. preparations of the barbiturates are: 0.3 gram barbital tablets; 0.3 gram barbital sodium tablets; 15, 30 and 100 mgm. phenobarbital tablets; 30 and 100 mgm. phenobarbital sodium tablets; 4 cc. (16

1. Snyder, M., Kiehn, C. and Christopherson, J.: Effectiveness of a Nitrofuran in the Treatment of Infected Wounds, Mil. Surg. *97*:380, 1945. **2.** McCullough, N.: Treatment of Infected War Wounds with a Nitrofuran, Indust. Med. *16*:128, 1947.



mgm./dose) of elixir phenobarbital; 30 and 100 mgm. pentobarbital sodium capsules, and 30, 50 and 100 mgm. pentobarbital sodium tablets.

PHARMACOLOGICAL ACTION AND USES

The barbiturates have an effective sedative and hypnotic action. For this reason they are used to a great extent in simple insomnia, hysteria, hyperthyroidism and certain nervous disorders. These drugs have a maximum hypnotic action combined with a minimum local irritant effect on the gastric mucosa. Although for this reason they may be dangerous if used promiscuously, their margin of safety is still greater than that of other hypnotics.

Small therapeutic doses have little or no effect on blood pressure and respiration in man. The slight decrease in respiration and blood pressure which may be observed is probably due to the general depressant action of the drug on the whole system rather than a depressant action on any particular center. Under proper conditions sleep can be induced within a half hour after the oral administration of a small dose.

However, in the presence of severe pain, repeated administration of barbiturates may cause delirium. In this respect the analgesic properties of the barbiturates differ markedly from those of the morphine derivatives and the salicylates. The latter drugs will produce analgesia without necessarily producing sleep or unconsciousness, while the barbiturates will not produce analgesia until the first stage of anesthesia has been reached.

If a patient is unable to go to sleep, but sleeps well once he is asleep, then the short acting barbiturates should be administered. In cases where the patient is unable to remain asleep for any length of time, an intermediate or long actor should be administered. Barbiturate induced sleep usually results in a refreshed awakening, but in some cases nausea, diarrhea and headache may appear after awakening. In the rare cases where the barbiturates produce excitement, insomnia and general restlessness, they should not be used.

It should be remembered that the duration of sleep and the after-effects produced depend not only upon which barbituric acid derivative is used and its route of administration but also upon the slight physiological and pathological changes which might exist among individuals. The barbiturates are used to augment the analgesic drugs, such as acetylsalicylic acid (aspirin), aminopyrine and acetophenetidin. Their use here is probably due to their sedative action.

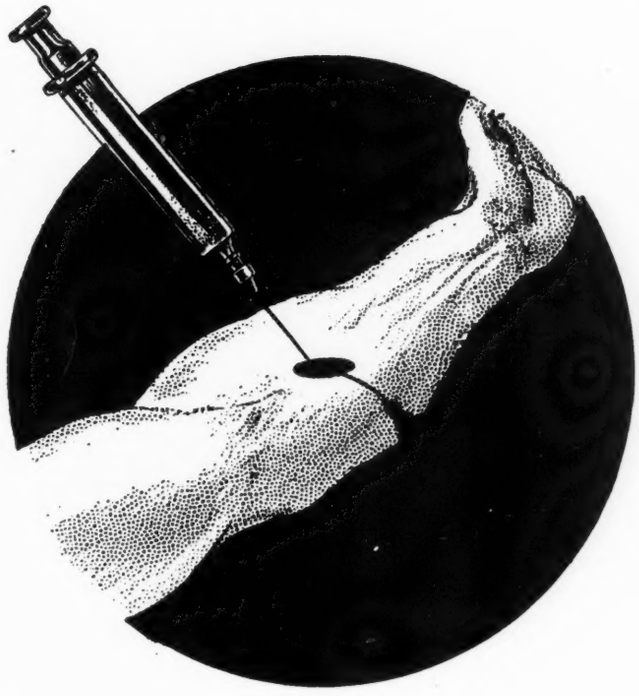
The longest acting barbiturates are used to produce sedation, and these should be administered in small, frequent doses. The sedative action of the barbiturates makes some of them quite useful as preanesthetic depressants. This is highly effective in eliminating preoperative excitability and in diminishing psychic trauma. Short actors may be used immediately before the operation, or the long actors may be used the night before.

Some obstetricians use short acting barbiturates during the early stages of labor. This produces amnesia but occasionally patients will enter the excitement stage of anesthesia and become uncontrollable.

However, the barbiturates fall short of meeting the requirements for an ideal anesthetic in two major aspects. First of all, the drugs are poor analgesics. Second, the large doses required for anesthesia cause a decrease in the margin of safety except in the case of the ultrashort actor pentothal which allows a fairly accurate moment to moment control owing to the rapid recovery after termination of injection, provided it is used for a short operation. When used for several hours, moment to moment control may be lost owing to accumulation of pentothal and a slower rate of degradation.

Convulsions of cerebral origin such as may occur with local anesthetics may be treated or prevented by the use of the barbiturates. The anticonvulsant properties of phenobarbital are probably a result of its long action. The use of this drug in epileptic therapy not only decreases the frequency of epileptic attacks but also decreases the violence of the attacks. The short acting barbiturates have been used in the psychic analysis of dementia praecox and other psychotic patients. Amytal has recently become popular as a "truth serum" used by police and psychiatrists in obtaining an "amytal interview" from suspected criminals. This drug acts to remove the criminal's mental resistance to questioning.

The heart rate and blood pressure are not affected by sleep producing doses of these drugs, but anesthetic doses will increase the heart rate and decrease the blood pressure. Acceleration of the heart rate is due to the



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1. Arbesman, C.E., et al., Jl. of Allergy 17:275, Sept. 1946
2. Feinberg, S.M., and Friedlaender, S., Am. Jl. Med. Sci. 213:58, Jan. 1947.
3. Fuchs, A.M., et al., Jl. of Allergy 18:385, Nov. 1947.

ISSUED: Scored tablets 50 mg. • Elixir, 5 mg. per cc.

[redacted]**RMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY**

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paralysis of the cardiac vagal nerve endings and, thus, removal of the inhibition of the heart rate. Toxic doses will decrease the force of the heart beat and will eventually stop the heart in the diastolic phase. The fall in blood pressure results from the direct action of all the barbiturates upon the smooth muscles of the arterioles.

Owing to its vasodilator action together with its depressant action, phenobarbital is used in the treatment of arterial hypertension and in the treatment and prevention of angina pectoris. The barbiturates are capable of depressing the smooth muscles, such as the stomach, intestines, bladder, ureters and uterus, by decreasing the general tonus. This property of these drugs makes them useful in labor because although they lengthen the duration of labor, they give much greater relaxation to the smooth muscles and increase the efficiency of the voluntary muscular contraction of the abdomen.

Although hypnotic and sedative doses do not greatly affect respiration, anesthetic doses decrease the respiratory rate and depth by acting on the respiratory centers in the medulla. The long actors may also produce death by pulmonary edema while toxic doses of the other members of the series cause death by respiratory depression.

All of the barbiturates except the long actors are destroyed in the liver, and the ultrashort thiobarbiturates are also apparently destroyed in the blood stream and kidney. Only the long actors, barbital and phenobarbital, are eliminated in the urine to any great extent. The others are partially degraded in the body and are excreted in the urine either as barbital or else as other metabolic fragments.

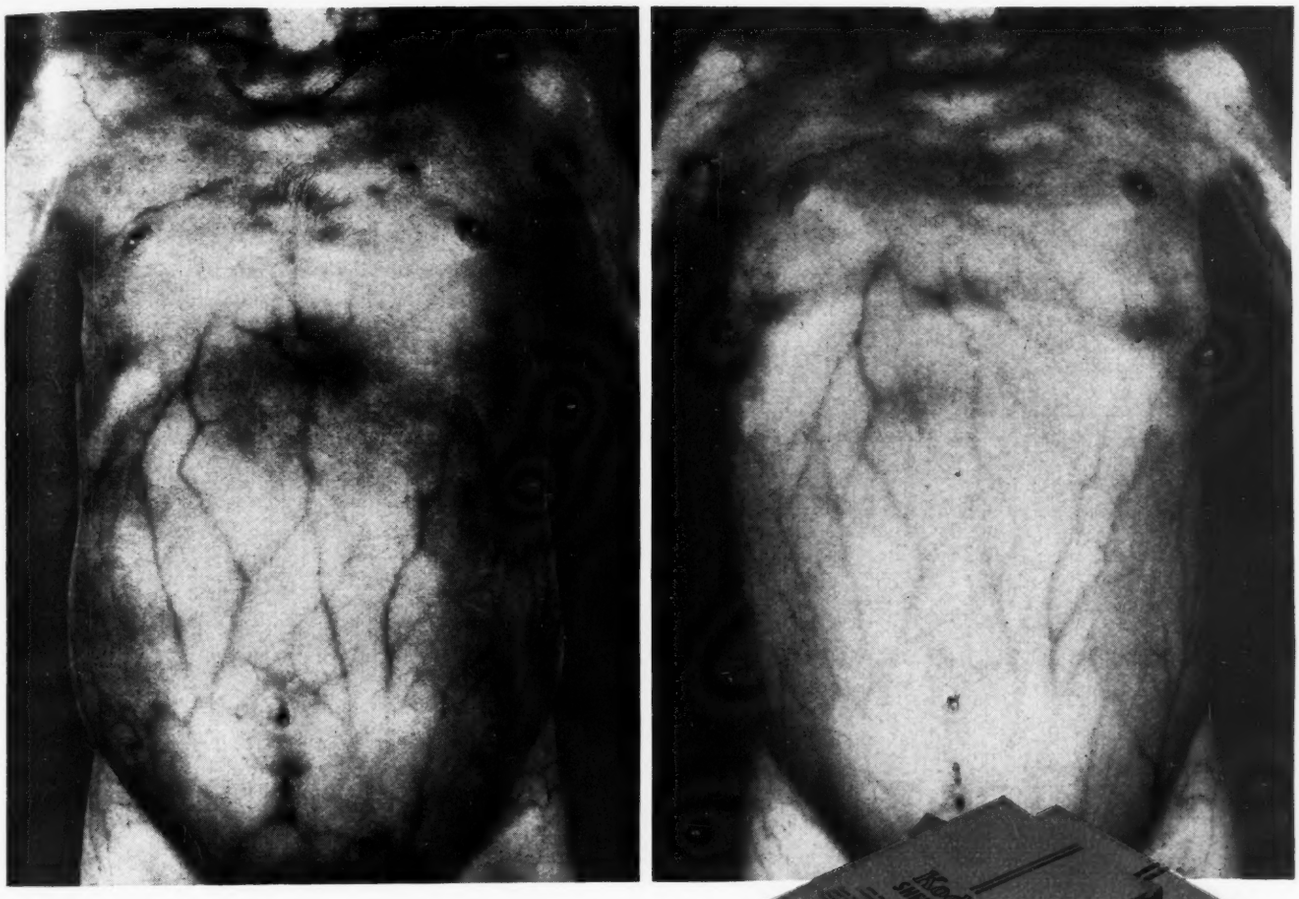
However, with massive doses, small quantities of the other barbiturates may spill over into the urine, thus indicating a high threshold for all but the long actors. Some patients develop a psychic dependence on and tolerance to the barbiturates. The drugs are often taken unintentionally in large doses, and a chronic poisoning occurs. The patient may fail to develop a deep sleep in some cases and may mechanically continue to take the remainder of the tablets in the bottle. This condition of "automatism" may result in accidental death.

The symptoms of this type of poisoning are deep coma, small fixed pupils, corneal anesthesia, low blood pressure, shallow respiration, and a fast weak pulse. Treatments for this type of poisoning are: (1) administer gastric lavage with activated charcoal in water, and allow 1 or 2 ounces of sodium phosphate or sodium sulfate to remain in the stomach; (2) maintain adequate respiratory exchange with oxygen therapy; (3) give 2 liters of isotonic sodium chloride hypodermically and 100 to 200 cc. of a 10 per cent glucose solution intravenously to act as diuretic agents; (4) administer 1 mgm. per minute of a 1:1000 picrotoxin solution until consciousness is resumed or until the limit of tolerance is reached (twitching of facial muscles), or amphetamine 20 to 60 mgm. intravenously every thirty minutes; (5) maintain body temperature.

Recently Osgood of the Milwaukee Sanitarium has reported convulsive seizures after withdrawal of barbiturates from nine patients who had taken sufficiently large amounts of the short acting barbiturates to become tolerant to their depressant effects. This phenomenon has also been observed by others in psychoneurotic patients who have taken an increasing dosage. None of these patients had ever had epilepsy.

In view of these marked abstinence symptoms and the frequency with which suicide is attempted with barbiturates (approximately one fourth of all cases analyzed at the Cook County morgue) more stringent control of the barbiturates is needed. Some state laws are adequate but are not well enforced.

Federal control, by having the barbiturates included in the Harrison Narcotic Act, would seem desirable. If this were effected, pentothal and phenobarbital for use respectively as anesthetics and sedatives should perhaps not be included. This recommendation may seem too strict but it is in accord with the opinions of toxicologists and some psychiatrists who feel that the barbiturates are as vicious in their action as are the opiates.—LEON H. BLOOM and CARL C. PFEIFFER, M.D.



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FOOD SERVICE

Conducted by Mary P. Huddleson

We Need a New Perspective on Hospital Food Service

ELVA J. KAHRS
Director, Dietary Department
Touro Infirmary, New Orleans

BEHIND modern hospital food service, with all its ramifications, lies a story of hard work, heartaches, frustration, backbreaking and endless tasks. The resultant effect, which stands today as a memorial to the unceasing efforts of ambitious dietitians, food service directors and farsighted hospital administrators, is certainly not an achievement with which to be satisfied. Nevertheless, it is such a far cry from the situation as it existed even less than a decade ago that it is well to pause and take inventory of our accomplishments, as well as to analyze their present day value, taking cognizance of both mechanical and human factors involved, inasmuch as a consideration of one is predicated on an understanding and involvement of the other.

THE ORDER OF THE DAY

Streamlining all aspects of business and industry has become the order of the day. Hospitals, too, must inexorably reflect the conversions that are the inevitable outcome of a major conflict such as the one through which we have just passed. While the food service appears to be one of the last—if not the very last—activities to receive justifiable consideration, it rightly deserves prime attention, both financially (because virtually one third of the hospital's entire budget is spent in its operation) and technically.

Boards of trustees, administrators, comptrollers and dietitians are now agreed that the food service should be placed in the proper perspective with relation to all other necessary activities of the hospital. Realization has come of the importance of good hospital food, not only because it facilitates patients' convalescence, but also for its value as a means of improving public and personnel relations.

Let us first consider the physical plant.

All of us are familiar with the gross disregard of expert dietary technical advice which has characterized hospital construction in the past, and I am certain, too, that many dietitians have been forced to cope with structural defects in their food service units which represent flagrant violations, shall we say, of all laws of efficient operation of a food production and service installation.

Architects and equipment experts are, of course, indispensable and I do not in any way seek to minimize the importance of their contribution; their functions have already been well and unquestionably established. What has not been done until recently—and that only in relatively few instances—is the correlation of the food service director's technical knowledge with that of the designer and the equipment adviser. Among other recommendations, a noted architect suggests that a planning team be developed which would consist of administrator, medical director, dietitian, architect and special consultant, in any circumstance involving construction of either a major or minor character concerned directly or indirectly with the dietary department.

Today, the compact, multistoried type of construction is preferred for hospitals, with the kitchen located on the ground floor. An elevator for the specific use of the dietary department should be provided, or its use should be diverted for at least the three serving periods of the day.

There are certain basic factors that must be considered in planning efficient, satisfactory kitchen installations. Of primary importance is the space provided, which should be adequate for work necessary and for expansion, should the hospital's total facilities be utilized. Additionally, where possible, *all* equipment, including exterior and interior surfaces and legs, should be of stainless metal. Adequate lighting and ventilation should be a major consideration at the outset, since these requisites unfortunately are often given a position of importance only when they are found to be woefully unsatisfactory at a time when little of a corrective nature can be done.

AIR CONDITIONING IS ESSENTIAL

It is well at this point to mention the need for air conditioning for the entire food production area, both from the standpoint of employes' health and from a psychological and economic standpoint. Comfortable, happy employes who feel their welfare is of real concern to the administration are certain to do more productive work with a minimum of loss in time and materials. Few people are aware of the appalling fact that during the summer months temperatures in most kitchens for the greater part of the eight hour work day range from 100° to 114° F.

Sufficient storeroom space with facilities for keeping adequate records, a perpetual inventory, and detailed but simplified food cost accounting should be made available. And I might appropriately remark here that only one avenue should exist by which both employes and supplies should travel, the advisability of which can readily be discerned.

Sound conditioning has become such an integral part of modern hospital planning that I need only mention it in passing. There is some question of the advisability of using acoustically treated ceilings in kitchens

From a paper presented at the Southeastern Hospital Conference, April 1947.

because of the possible clogging of the holes with greasy vapors, creating probable breeding places for vermin. However, acoustical materials are on the market which represent an improvement over older types, and with which the aforementioned disadvantage is not noted. The essentiality of sound conditioning in dishwashing areas and service pantries is unquestioned. In dishrooms, ceilings, as well as a portion of the walls, should be sound treated.

Efficient selection and expert placement of equipment not only result in more satisfactory food service in all its aspects, but are reflected in real economies for, obviously, efficiency practices that are fundamentally sound make possible a reduction in the number of employes necessary to do the job, decrease operating costs, minimize hazards, and enhance standards.

Following the topics of physical layout and selection and placement of equipment naturally comes a consideration of personnel, the first facet of which is proper selection of a technically trained staff, beginning with the director of the dietary department. Whether the hospital is large or small, it is of paramount importance that the individual in charge of food service be fully qualified to perform satisfactorily the duties incumbent upon her. This implies active membership in the American Dietetic Association.

STATE REGISTRATION PROPOSED

Legislation establishing state registration of dietitians is underway in some states but has not yet become law. Assuredly, action should be taken, inasmuch as numerous unqualified individuals are masquerading as dietitians to the discredit of the profession as well as of those persons whose academic and personal qualifications entitle them to membership in the American Dietetic Association, the accrediting organization of the profession. An applicant for membership in the American Dietetic Association must have completed the association's academic requirements leading to a bachelor of science or a bachelor of arts degree with a major in foods and nutrition from a college or university of recognized standing, followed by a year's internship in one of the 71 association approved training courses.

The standard is one qualified dietitian for every 40 or 50 patients in a voluntary general hospital. In smaller hospitals this figure will vary and a high degree of specialization among dietary staff members is not possible. However, where the situation allows, it is highly desirable to have a division of responsibility and duty. While the dietitian is discharging her function of improving and maintaining the well being of both patients and personnel, she is also serving in an educational capacity, teaching nutrition principles, for both the normal and abnormal condition, to individuals and groups.

The difficulty of procuring well trained dietitians is only a little more acute than that of obtaining skilled kitchen help. In addition to the conventional staff line-up, which usually includes therapeutic, administrative, ward, educational and clinic dietitians, as the individual situation demands, it is of prime importance both for the sake of economy and from an efficiency standpoint to have available in the department a personnel dietitian to train and orient new employes.

Salaries of dietitians should be comparable to the compensation in allied professions and positions of like responsibility in order that experienced desirable staff people can be retained. Remuneration in all spheres should be commensurate with the quality of work demanded, the amount and character of training required—both academic and practical—and with the length of time employed, and some systematic scheme for routine salary increases should be provided both as recognition for work well done and as an incentive to greater and more productive endeavor.

In recent years rapid and spectacular strides have been made in the direction of improving food facilities in virtually every zone of operation. While an elaboration of these facilities is not feasible here, at least mention should be made of the most modern ones, some of which include frozen and dehydrated foods in all forms, electronically heated ovens, induction electrical cooking appliances, and electrically operated individual garbage disposal units.

In my opinion the greatest single alteration in the equipment requirement of the kitchen will be radically increased refrigeration space necessitated by the extensive use of frozen items. It is conceivable that in a relatively short time conventional methods of food storage and preparation will be obsolete; time required for production will be reduced from hours to minutes; changes in personnel requirements will be revolutionary; cost of operation — when present problems of equipment production are ameliorated—will be drastically cut. The course of food from its receipt at the back door to its service to the patient, aided by disposable units in place of china, glassware and silver, will be dramatic, completely standardized and scientifically synchronized.

All of this ultra-modernization naturally projects the question of centralized *versus* decentralized tray service. It will become obvious that either with prefabricated meals, as it were, or with present methods of food preparation and service, a combination of the two types must be employed in most hospitals.

DECENTRALIZATION MANDATORY

With an institution whose physical plant is spread over a wide area, or one to which annexes have been added, virtual decentralization becomes mandatory if a high standard of food service is to be maintained. On the other hand, in a vertical, multistoried plant, centralized tray service is highly satisfactory if transportation problems can be met with correct equipment. In both types of construction, a preponderance of one kind of service or the other will be found necessary to meet the institution's requirements.

From the standpoint of economy, decentralization in the vertical plant is preferable, particularly with reference to personnel involved. Actually, by establishing floor service pantries or kitchens, it is possible to reduce the number of employes necessary to serve food properly. Furthermore, it is apparent that food will reach the patient in much better condition than if it were brought varying distances from a central serving area and subjected to all the difficulties encountered en route, such as inclines and elevators that do not consistently level off with the floor, with the attendant evils of hot foods cooling, ice cream melting, and salads wilting. Individual floor service units would obviate all this and would, of course, make really satisfactory food service an actuality.

The measure of a plan's success is not how quickly the trays leave the serving unit in a given time, but how well they measure up nutritionally, whether the patients receive them satisfactorily, and whether economy of

time and materials is an observable fact from the setting up of the tray to its final dismantling.

Floor kitchens should be centrally placed so that all patients served by these units can be reached with a minimum of steps. A consideration of the relationship of the main kitchen to the service units is of prime importance and, as mentioned before, elevators expressly for the use of the dietary department should be maintained at least during the serving hours.

Equipment in these kitchens should be placed for greatest efficiency, which precludes the prevailing practice of arranging equipment against the walls when a central or assembly-line arrangement—or a combination of the two—would result in greater efficiency.

THE FUNCTIONAL BASIS OF HOSPITAL PLANNING

REFRIGERATION EQUIPMENT

Continuing a Study by the
Division of Hospital Facilities
United States Public Health Service

BOXES

PORTABLE "reach-in" boxes may suffice in the smallest hospitals. However, most hospitals will require walk-in boxes. The sizes of these boxes are determined by the number of patients and personnel to be served and the frequency of food deliveries. The markets available and the buying policy of the hospital will determine whether deliveries will be made daily or weekly.

The smaller hospitals, with frequent deliveries, may operate satisfactorily with two boxes, one for meats and the second for vegetables, fruits and dairy products. For the larger hospitals, three walk-in boxes are recommended to permit separate storage of dairy products. In addition, smaller boxes are required for the baker and cook, and for salads, fish and leftovers. Separate boxes must be used for frozen foods as they require lower temperatures than do other foods.

The insulation of the boxes must be vaporproof to prevent moisture from penetrating to the cold surface where it would condense and freeze. The walls can be sealed by setting the cork or insulating material in mastic cement and finishing the inner and outer surfaces with a waterproof coating; where the insulation is applied against a masonry wall, the masonry is waterproofed and the insulation is applied with mastic cement.

Self-supporting walls are formed with waterproofed wood studs, with 2 inch insulation between the studs and on the inside surfaces. The cork or other insulation is set in plastic cement and secured with wood skewers. It is preferable to lay the insulation in two thicknesses to break the vertical and horizontal joints.

Ceilings can be as low as 7 feet 6 inches if overhead bunkers are not used. They are usually supported by galvanized "T" irons, with the first 2 inch course of insulation resting on the flanges. The second course can then be laid in plastic cement above the "T" irons. The top surfaces must be waterproofed and finished as required, but usually the space above the boxes is a dead air space, formed by carrying the outer plaster to the kitchen ceiling. Where the boxes are set on a concrete slab it is customary to omit the floor fill and lay the insulation in plastic on the rough slab. The insulation should be protected by membrane waterproofing turned up at the walls, on which the floor fill can be poured.

Tile floors with cove bases are generally used, but it is important that the concrete and grouting be of an approved acidproof type as acids from fats and milk will disintegrate ordinary concrete. Floors should pitch to a floor drain, which is connected with a non-return flap over an outside floor drain to prevent sewer gas or insects from entering the boxes.

The thickness of the insulation for boxes is determined by the efficiency of the insulation and the temperatures to be maintained. The meat boxes are usually planned for a temperature of 350° F. and those for vegetables and dairy products, for a temperature of 40° F. For these temperatures the insulation should be equal to 4 inches of pressed cork. The insulation for partitions between boxes may be reduced to 3 inches. It is generally agreed that the frozen food boxes should be maintained at 0° F. and require insulation equal to 8 inches of cork.

Doors must be of substantial construction, gasketed to prevent air infiltration and heat losses. These doors are manufactured by companies specializing in this work and can be purchased with trim and jambs ready for installation. They may be furnished with glass panels to permit inspection without opening the doors. They are available with natural wood finishes or with stainless metal sheathing.

The cooks', bakers' and other reach-in boxes are usually fitted with upper and lower doors. Frozen food boxes should be designed with refrigerated vestibule compartments. Reach-in boxes are favored by some for frozen foods; it is possible for a person to reach any stored item without raising the box temperature or being exposed to low temperatures. When such boxes are used they should be set in a refrigerated space. The dive-in type of box is not recommended.

Special hardware is required on such doors to maintain a tight seal and because of the unusual weight. The most efficient hinge is one that will maintain pressure on the gasket although the thickness of the gasket may vary with use. The door latches should be heavy and of the type that

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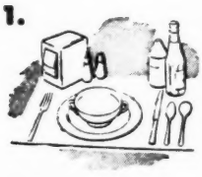

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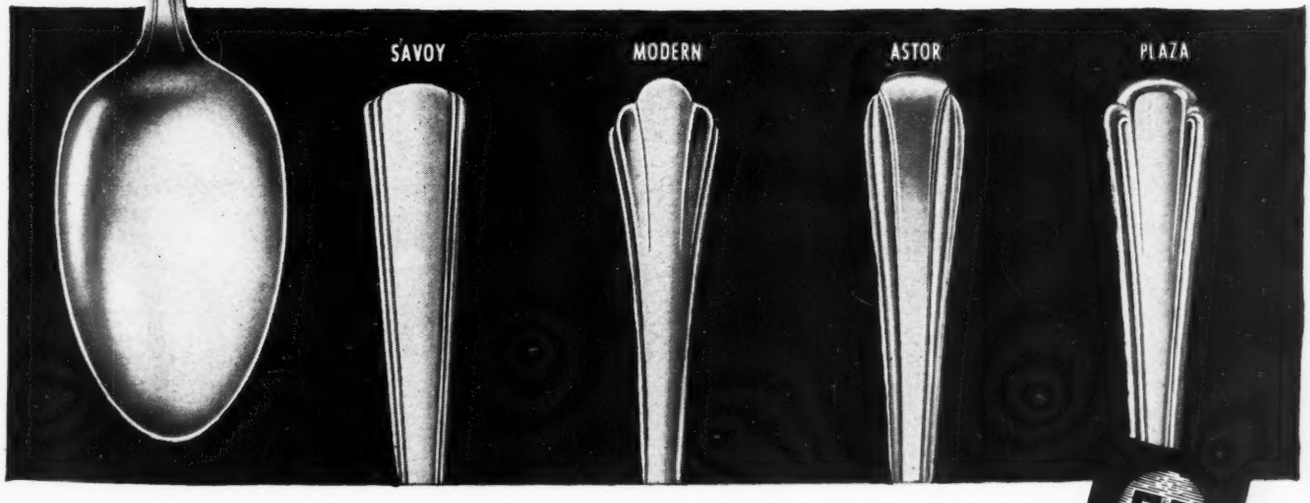

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Tile floors laid in acid resisting cement with cove base are generally used. Plaster, applied over galvanized metal lath and finished with painted Keene cement, has been used extensively for wall and ceiling finishes. However, this is objectionable as it must be painted regularly and may be damaged by crates and cans. When plaster is used it should be scored to divide the wall surfaces into squares. Tile laid in acidproof cement and pointed up with acid resisting cement provides the most enduring and sanitary wall surface, requires little maintenance, and is easily cleaned.

Hot dipped galvanized slatted adjustable shelves, meat hooks, racks and supports are manufactured by companies specializing in such equipment. These should be selected to meet the requirements of the foods to be stored. Supports for such equipment should be provided in the construction. Supports for coils or fan cooling units, as well as electrical conduits and boxes, must be set when the boxes are being built. Vaporproof lighting fixtures and fan outlets are required and should be wired with lead sheathed circuits. Control switches are located outside the boxes. All conduits for electrical circuits and refrigerant lines must be sealed air tight.

The refrigerant used in any part of the hospital must be a nontoxic, nonirritant gas. Multiple refrigerating machines are preferable as one compressor will not operate as efficiently with boxes of different temperatures. The use of two or more compressors with cross connections also guarantees against complete shutdown.

Water cooled condensers are more efficient than are air cooled units except where the cost of water is excessive. Automatic water shut-off valves will prevent the waste of cooling water. Thermostatic control is required for each box where more than one is refrigerated by a single machine. The refrigerator machines should be located in a room near the boxes and arranged for easy inspection and repairs. Conduit may be built in to permit the installation of the refrigerant tubing after the boxes are completed, but this conduit should be sealed air tight where it enters the boxes.

When cooling coils are installed overhead, the ceiling of the box must be higher than is necessary with fan cooling units. The coils should be mounted on the ceiling with baffles to increase the circulation of air. It is claimed that, with the fan cooling units, defrosting can be reduced and a higher humidity can be maintained to reduce the drying of the foods.

Flake ice machines are being more generally used for cracked ice, as they are more sanitary and save labor. The flake ice should be discharged into an insulated icebox, which can be refrigerated for storage. Ice from these machines has not proved satisfactory for oxygen tents, but refrigerated tents that require no ice are now available.

DRINKING WATER

When water is to be cooled for drinking, a central refrigerated cooling system should be used in preference to small self-contained units for ice. The water cooling tanks should be of the closed type, connected to the outlets with supply and circulating pipes covered with cork or equivalent insulation. Drinking water outlets should be located at the drinking fountains, in floor pantries, at cafeteria counters and in service pantries.

Menus for April 1948

Bertha M. Fuller
Nebraska Orthopedic Hospital
Lincoln

1
Orange Juice
Toast and Jam
•
Roast Beef With Gravy
Mashed Potatoes
Buttered Onions
Carrot Sticks or Pickles
Coconut Custard Pudding
•
Spaghetti With Ground Meat and Tomato Sauce
Lettuce With Dressing
Cookies, Fruit and Milk

2
Bananas
Hard Cooked Eggs, Toast
•
Haddock Fillets, Hot Fish Sauce
Baked Potatoes
Stewed Tomatoes
Celery Hearts
Pineapple Sauce
Graham Crackers
•
Cream of Asparagus Soup
Heated Crackers
Sliced Cream Cheese
Cabbage and Raisin Salad
Rye Crisp

3
Stewed Prunes
Coffee Cake, Jelly
•
Roast Pork
Mashed Potatoes, Gravy
Spinach
Baked Apples
Cookies
•
Plate of Assorted Meats
Fried Raw Potatoes
Tossed Salad
Home Made Buns
Cherry Pudding With Sauce

4
Rhubarb-Raisin Sauce
Poached Eggs, Rusks
•
Chicken à la King
Mashed Potatoes
Fresh Asparagus
Carrot Sticks
Ice Cream
•
Chicken Soup
Hard Cooked Eggs
Potato Chips
Cake
Fruit

5
Orange Juice
Rice With Raisins
•
Meat Loaf
Parsley Potatoes
Harvard Beets
Green Onions
Peaches With Custard Sauce
•
Vegetable Plate
Molded Fruit Salad
Muffins
Chocolate Pudding

6
Sliced Oranges
Bacon, Toast
•
Broiled Liver
Creamed Potatoes
Buttered Carrots
Sweet Pickles
Lemon Pie
•
Cottage Cheese and Egg Balls
Mixed Green Vegetable Salad
Spice Cake With Meringue Topping

7
Stewed Dried Apricots
Baked Eggs, Toast
•
Steaks
Shoe String Potatoes
Peas
Sweet Pickle Relish
Ice Cream
•
Tomato Rabbit on Toast
Cabbage, Carrot and Celery Salad
Hot Rolls
Fruit Cup
Oatmeal Cookies

8
Assorted Fruits
Scrambled Eggs
•
Barbecued Beef Patties
Browned Potatoes
Spinach
All-Bran Pudding
•
Vegetable Soup
Heated Crackers
Toasted Cheese Sandwiches
Peach Sauce
Cookies

9
Prune Juice
Toast and Jelly
•
Salmon Loaf With Tomato Sauce
Parsley Potatoes
Fresh Vegetable in Season
Radishes
Cheese Cake
•
Clam Chowder
Egg Sandwiches
Relish
Rice Pudding

10
Bananas
Poached Eggs, Toast
•
Pork and Beef Patties
Hashed Brown Potatoes
Wax Beans
Raw Relish
Orange Sherbet
•
Split Pea Soup
Heated Crackers
Date Bread Sandwiches
Cottage Cheese Salad
Royal Anne Cherries

11
Orange Juice
Toasted Sweet Rolls
•
Roast Beef, Gravy
Mashed Potatoes
Broccoli
Fruit Salad
Ice Cream
Cookies
•
Cream of Tomato Soup
Heated Crackers
Tuna and Celery Salad
Canned Fruit
Frosted Cup Cakes

12
Blended Fruit Juice
Crisp Bacon, Rolls
•
Baked Ham, Raisin Sauce
Parsley Potatoes
Buttered Cauliflower
Pickled Peaches
Rhubarb Crisp, Whipped Cream
•
Ham Sandwiches
Potato Chips
Stewed Tomatoes
Fruit Cup

13
Canned Figs
Soft Cooked Eggs
•
Hamburgers With Tomato Sauce
Baked Stuffed Potatoes
Buttered Broccoli
Blueberry Pudding
•
Baked Noodles and Chicken
Lettuce Salad
Whipped Gelatin
Ice-Box Cookies

14
Grape Juice
Toast, Crisp Bacon
•
Veal Chops
Parsley Potatoes
Harvard Beets
Clover Leaf Rolls
Royal Anne Cherries
•
Consommé
Eggs à la Goldenrod
Buttered Asparagus
Celery Hearts
Ice Cream
Vanilla Cookies

15
Orange Juice
Poached Eggs, Toast
•
Baked Ham
Escalloped Potatoes
Buttered Green Beans
Butterscotch Pie
•
Tomato Rabbit on Toast
Ham Sandwich Spread
Fruited Lemon Gelatin
Cookies

16
Grapefruit Halves
Baked Eggs, Rolls
•
Salmon Loaf
Browned Potatoes
Cauliflower
Sweet Pickles
Vanilla Ice Cream
•
Vegetable Casserole
Mixed Fruit Salad
Peach Cobbler

17
Blended Fruit Juice
Scrambled Eggs
•
Grilled Beef Liver
Parsley Potatoes
Stuffed Baked Onions
Carrot Sticks
Rice Pudding
•
Cream of Vegetable Soup
Heated Crackers
Rice
Sliced Bologna
Peas
Sliced Pineapple

18
Orange Halves
Crisp Bacon, Jelly
•
Chicken à la King
Mashed Potatoes
Green Lima Beans
Fresh Tomato Salad
Chocolate Ice Cream
•
Chicken Noodle Soup
Deviled Eggs
Potato Chips
Celery or Relish
Fruit Cocktail
Hermit Cookies

19
Grape Juice
Crisp Bacon, Toast
•
Grilled Hamburgers
Au Gratin Potatoes
Buttered Beets
Romaine Salad
Date Torte
•
Cream of Tomato Soup
Toasted Cracker and Cheese Sandwiches
Luncheon Meat
Cottage Pudding With Fruit Sauce
•

20
Prune Juice
Baked Eggs, Toast
•
Cube Steaks
Shoe String Potatoes
Cabbage Slaw
Stewed Tomatoes
Snow Pudding
•
Clam Chowder
Mixed Vegetable Salad
Clover Leaf Rolls
Pineapple
Chocolate Cookies

21
Orange, Grapefruit Sections
Poached Eggs, Toast
•
Roast Lamb
Seasoned Steamed Potatoes
Buttered Green Beans
Beet Relish
Banana Cream Pie
•
Vegetable Soup
Spaghetti With Meat and Tomato Sauce
Prune Whip

22
Grapefruit Juice
Crisp Bacon, Toast
•
Meat and Vegetable Pie
Tomato Gelatin Salad
Pistachio Ice Cream
Cookies
•
Pineapple Juice
Baked Hamburgers
Creamed Potatoes
Buttered Green Beans
Blackberries
Peanut Cookies

23
Orange Halves
Coddled Eggs, Toast
•
Haddock Fillets, Hot Sauce
Stuffed Baked Potatoes
Fresh Spinach
Lemon Pudding
•
Split Pea Soup
Oyster Crackers
Deviled Eggs
French Fried Potatoes
Royal Anne Cherries
Cup Cakes

24
Canned Apricots
Corn Meal Mush
•
Short Ribs en Casserole
Mashed Potatoes
Stewed Okra
Pickles
Peach Brown Betty
•
Creole Soup
Wheat Sticks
Toasted Cheese Sandwiches
Fresh Fruit Cup
Graham Crackers

25
Sliced Oranges
Baked Eggs, Toast
•
Veal Pot Pie With Dumplings
Watercress and Fruit Salad
Buttered Wax Beans
Lemon Chiffon Pie
•
Eggs à la King on Toast
Lettuce Salad
Chocolate Cake With Whipped Cream

26
Assorted Fruit Juices
Crisp Bacon, Toast
•
Whole Baked Ham, Raisin Sauce
Parsley Buttered Potatoes
Wax Beans
All-Bran Carrot Pudding
•
Tomato Rice Soup
Crackers
Sliced Tongue
Baked Potatoes
Asparagus
Ice Cream

27
Pineapple Juice
Scrambled Eggs, Toast
•
Liver Loaf
Stuffed Baked Potatoes
Stewed Tomatoes
Shallots
Orange Sherbet
•
Chicken Noodle Soup
Toasted Bread Squares
Cold Roast Beef
Mixed Green Vegetable Salad
Date Pudding

28
Grape Juice
Cinnamon Toast
•
Chicken à la Maryland
Mashed Potatoes, Giblet Gravy
Buttered Sweet Peas
Hot Parker House Rolls
Loganberry Whip
Wafers
•
Split Pea Soup
Heated Crackers
Sliced Cold Bologna
Buns
Fruit Salad
Baked Custard

29
Vegetable Juice
Soft Cooked Eggs
•
Swiss Steak
Mashed Potatoes, Gravy
Stewed Tomatoes
Crystal Pickles
Butterscotch Ice Cream
•
Chicken Croquettes
Creamed Potatoes
Tomato Salad
Loganberries

30
Bananas
Crisp Bacon, Toast
•
Halibut Steak With Tomato Sauce
Shoe String Potatoes
Vegetable Salad
Clover Leaf Rolls
Lemon Pie
•
Creamed Fresh Asparagus on Toast
Potato Soup
American Cheese
Beet Salad
Vanilla Ice Cream Puffs

Ready-to-eat or cooked cereals are offered on all breakfast menus.

MAINTENANCE AND OPERATION

IT DOESN'T TAKE MUCH TO START A FIRE

RALPH FULTON

Fire Protection Institute
New York City

AT 1:30 p.m., Feb. 3, 1947, a fire was discovered in the attic of a Nova Scotia mental hospital. Within minutes flames were roaring through the antiquated wooden structure.

As the fire mounted in ferocity the attendants fought their way into the seething inferno and rescued ninety-seven of the patients. When the fire was finally quelled, the bodies of two of the patients were found in the rubble. That there were only two deaths is a tribute to the heroism and training of the hospital staff.

The exact cause of the fire will probably never be determined. All that is known is that the blaze was discovered in the attic and, significantly enough, near a chimney! Because the building was wood and lacked sufficient fire protection devices it went up like dry grass.

But how about *your* hospital? Is it fully protected from the ravages of fire? It doesn't take much to start a blaze, you know.

It only took a defective ceiling light in the kitchen of a Massachusetts hospital to start a fire that caused $35,000 worth of damage. An approved fire extinguisher might have nipped this blaze in the bud.

Could such a fire start in your institution?

If you remove as many hazards as possible, you will deal fire a telling blow. If you install such fire protection equipment as approved extinguishers throughout the building, you will have followed through with a knockout punch.

In the interest of safeguarding your hospital, some of the commonest fire hazards are listed.

Minneapolis Star Photo.

The fire department demonstrates proper fire fighting technics.

Electricity

In most cases, the original wiring job, installed by qualified electricians, will conform with all the fire safety standards. But when "handyman" alterations are made, a dangerous condition arises. Never let anyone but a competent electrician change your electric circuits.

Misuse of extension cords is the violation most frequently found. Never run cords under rugs, over hooks or through doorways. Such practices subject the cord to undue wearing. The use of extensions should be countered with installation of more base plugs.

Improper fusing is also a dangerous condition encountered in hospitals. If more people would remember that the fuse is to the light circuit what the valve is to the steam boiler, there would be fewer electrical fires. The average light circuit takes a 15 ampere fuse. Never should a penny be used!

At least once a year a qualified electrician should inspect the entire electrical system. This small expense might spare your institution the awful consequences of a fire.

Heating

All heating units should meet underwriters' specifications and should be installed by qualified heating experts. The furnace, pipes and ducts should be checked periodically, for signs of wearing. Loose pipes should be repaired immediately to prevent sparks escaping into the basement.

Make sure all ducts are at least 18 inches from any wood beams or other combustible material. Be wary of blackened beams because that means the pipes are too close for safety.

Metal cans, *not* wood crates or boxes, should be used for ash disposal.

Incinerators

If you dispose of rubbish in an incinerator, be sure it conforms with the standards of insulation and con-

STRETCHES YOUR PRODUCTION PER SQUARE FOOT

THE HOFFMAN UNLOADING "SILVER CREST"

More loads per day can be handled by the "Silver Crest" because it unloads in seconds instead of minutes. In the time usually required for pulling loads from conventional washers, the Hoffman Unloading "Silver Crest" can be well on its way to processing additional loads. Net result is more abundant linen supplies to meet today's increased demands—without increase in washroom floor space. And with economies in labor and linen life. The Unloading "Silver Crest" is a modern solution to your problem of how to get more for your hospital laundry dollar—ask us to give you complete details now.

ASK FOR THIS FREE SURVEY

For adequate, balanced supplies of clean linen, Hoffman experienced technicians analyze your laundry operating costs; survey your linen requirements and suggest linen control schedules; furnish efficient new laundry layout plan; recommend equipment to help you save floor space, save time and labor, save fuel and supplies, and save linen.

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struction laid down by the underwriters' code.

Ventilation

Adequate ventilating equipment should be installed to supply fresh air for the patients. This equipment should not, however, provide a means for distributing smoke and flame throughout the building should fire break out.

Kitchens

Hazards in the kitchen arise principally from ranges, ovens and broilers and their ventilating ducts. These appliances should be installed on fireproof flooring.

If masonry is used, it should be hollow at the ends to prevent heat from concentrating at one point.

Hoods and ducts should be kept free of grease and dust accumulations. Filters of a special type installed under the hoods have been found highly effective in preventing heavy collections of grease.

Laundry

If the laundry room is located in the hospital building, it should be separated by fireproof partitions and walls. All entrances should be equipped with a fire door.

Electric hand irons should be checked frequently for frayed cords or loose connections. Impress upon your employes the fact that 40 fires each day are caused by misuse of these irons. All steam lines to washing machines, mangles and dryers should be well insulated and placed away from the woodwork.

Laboratories

Bunsen burners and other gas heaters should be mounted and so handled as to guard against ignition of nearby flammable material. Technicians should be warned against the dangers of temporary wiring. Before any changes in the wiring system are made, the advice of the local electrical inspector should be obtained.

Do not stock unnecessarily large supplies of dangerous chemicals.

By all means post "No Smoking" signs conspicuously!

X-Ray Film Storage

Nitrocellulose x-ray film must be handled with the utmost care, because of its highly combustible nature. The film should be stored in a vented storage vault either detached from the hospital or on the roof. Ventilating equipment is necessary for the dispersal of any dangerous fumes created by nitrocellulose.

Operating Rooms

"There is no room in the hospital where the need of safeguards is so essential as the operating room," reports the National Board of Fire Underwriters.

The danger in an operating room is chiefly from the use of combustible anesthetics. When oxygen is mixed with them in the proper proportions, ether, ethylene and ethyl chloride become explosive. Therefore, every effort should be made to prevent the use of open lights, high frequency electrical apparatus, or live cauteries in the vicinity of these flammable gases.

Smoking should be absolutely prohibited!

If possible, the operating room should be separate from the rest of the building so as to facilitate removal of an unconscious patient in case of fire.

Housekeeping

Sloppy housekeeping goes hand in hand with fire. Keep your cellars, basements, floors and attics swept out. Never let rubbish and waste accumulate.

Be especially careful with combustible cleaning supplies. All rags used for janitorial duties should be kept in tightly closed metal containers.

Old furniture should never be allowed to clutter the attic. An attic that serves as a catch-all for assorted debris is a dangerous fire hazard.

Even after all these precautions have been taken, the possibility of a hospital fire's breaking out is certainly not erased entirely. Coupled with the removal of fire hazards is the necessity for installing up-to-date, approved fire extinguishers.

There is an extinguisher for every kind of hospital fire. Electrical fires, for instance, should be controlled with an extinguisher loaded with either carbon dioxide or vaporizing liquid. Water or unapproved chemical agents have caused people to be electrocuted. Operating rooms should be equipped with foam or loaded stream type of extinguishers.

By keeping constantly vigilant you will be doing much to assure your patients that a hospital is what it should be—a safe haven for the curing of ills.

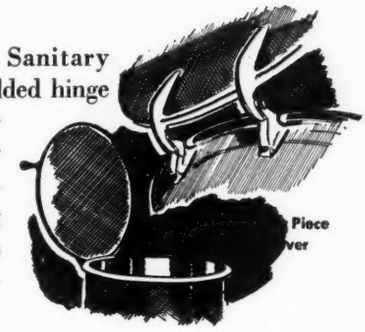
Be prepared for fire!

ING the new Steam-Jacketed Kettle

which aluminum conducts heat. Now the *new* Wear-Ever kettles give you this same important advantage plus many others . . .

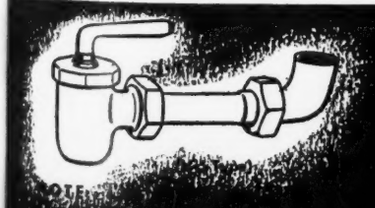
tivity of the *thick* one-piece aluminum shell is so rapid, these kettles cook even above the jacket line! Will operate at pressures up to 40 or 80 lbs. depending on kettle size. Has adjustable feet for perfect leveling.

for easy cleaning. The Sanitary Single Piece Cover has welded hinge pads. Cover extends over kettle bead enabling cover to be cleaned without danger of dirt or fluids getting into kettle. Both covers available with stain-resistant Alumilite finish.*



aluminum alloy with almost twice the strength of the aluminum used in pre-war Wear-Ever kettles. *There are no inside welds!* Thickness of shell and jacket range from 3/32" to 25/64" depending on size of kettle. The *new* sanitary bead is left *open* for easier cleaning! Highly polished finish on outside if desired.*

40-GALLON SIZE
with Single Piece Sanitary Cover and Vertical Sanitary Draw-Off. Other sizes from 10 to 150 gallons.



WEAR·EVER
Aluminum

WRITE FOR MORE INFORMATION about this amazing new line of Wear-Ever Aluminum Steam-Jacketed Kettles. The Aluminum Cooking Utensil Company, 703 Wear-Ever Building, New Kensington, Pa.

HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

A Nursing Director Says:

HOUSEKEEPER AND NURSE ARE CO-THERAPISTS

FLORENCE M. GIPE, R.N.
Director
Division of Nursing Education
and Nursing Services
University Hospital, Baltimore

FLORENCE NIGHTINGALE, in her early writings, stated that the laws of God were discoverable by experience, research and analysis. In this stated philosophy, which can be applied to the vocation of executive housekeeping, she referred to the mental and physical aspect of nursing both as an art and as a science. Her aim, at all times, was to resort to sound reasoning, and she demonstrated the truth of her thesis when she went to the war in the Crimea and found the institutions so badly in need of a woman's touch. She, first of all, put her house in order and reduced the death rate of the soldiers from 40 per cent to 2 per cent in a little more than two months.

The public at that time thought of Florence Nightingale only, or mainly, as the gentle nurse, but really that alone did not make her what she was. Men who observed her stated that she was outstanding for her work as an administrator, for she really could get things done.

CLOSELY ALLIED TO NURSING

Executive housekeeping is closely allied to nursing and was at one time handled by the matron, later called the superintendent of nurses. When a course in hospital administration was introduced at Columbia University in the beginning of the twentieth century many subjects which are important to housekeeping were included in the curriculum. Among these were: hospital construction, sanitation, ventilation, arrangement of utility rooms, wards, toilets, serving rooms, laundry room and kitchens. Many hours were spent by the early pioneers in discussing the disposal of waste, lighting, personnel management and home duties. How familiar to all of us these subjects seem. Even today, the same problems seem insurmountable at times because new occasions teach new duties.

When a student enters the school of nursing, one of her first periods of study and work is utilized to develop an appreciation and understanding of the effect on the patient of a safe, comfortable and attractive environment. You housekeepers, as environmental specialists, play an important part in the education of this young nurse because you assist, or should assist, her to develop the ability to carry out skillfully some fundamental principles involved in creating cleaner, more beautiful, and wholesome surroundings.

The student must learn early in her course the value to the patient of a cheerful outlook; ways of providing pleasing color effects and color combinations; orderliness of environment; effects produced by various types of window shades and draperies; flowers and flower arrangements; use of fabrics in blankets, linens, cushion covers; importance of safety devices on elevator doors, exit lights and signs. Many more could be enumerated that are essential aside from the physical care included in nursing.

If we could take an opinion poll our patients would undoubtedly tell us that the most important factor in speeding their recovery was a clean, colorful and quiet environment. How many of us recall the days when our hospitals were furnished throughout in white—white iron beds, white bedspreads, white window curtains, even white china. Was there any wonder that the average guest felt as if he were going into a death chamber? Many records show that patients in the early days of hospitals died from fright upon admission. The drab gray walls in the wards and common disorder throughout the institution are ably depicted in the history of Bedlam.

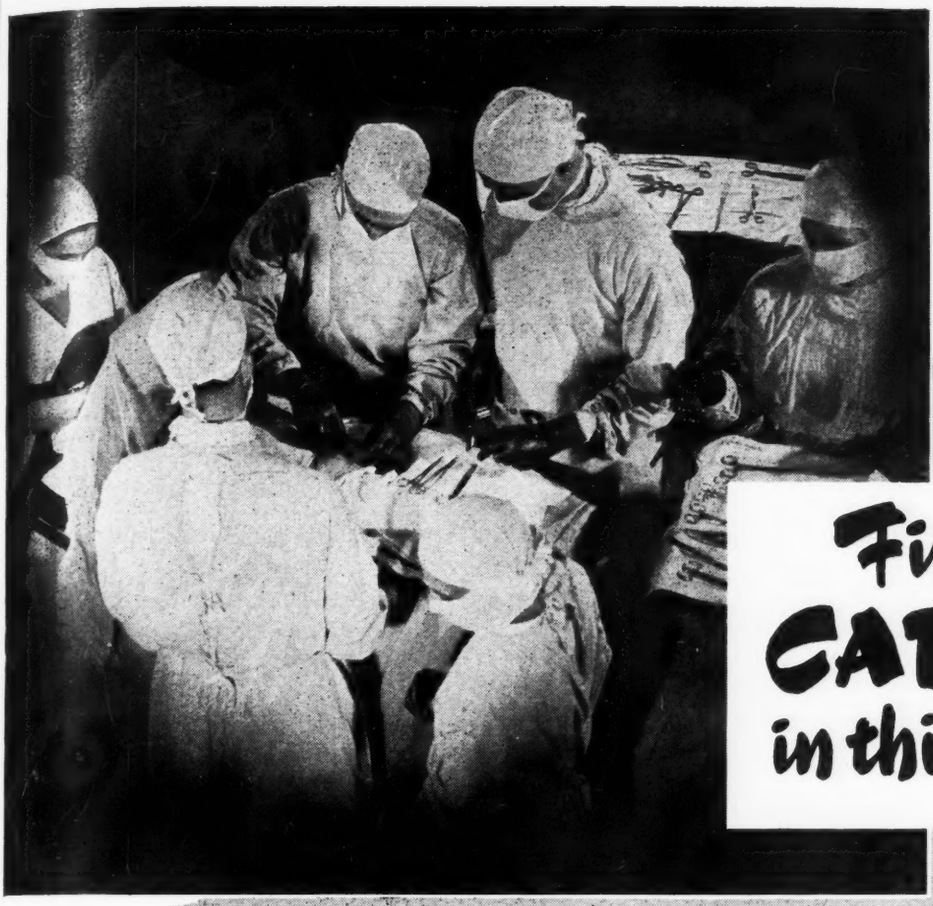
Just as many other types of work have advanced, so has hospital management. Organization plans have been made, and the executive housekeeper is now important to the social well-being of all concerned. You came with women's ideas, and made our hospitals and hotels assume a homelike atmosphere. Through artistic aptitude, experience and analysis you introduced beautiful color schemes into what were formerly depressing surroundings. In creating this transition much diplomacy was required.

FRICTION CAN BE AVOIDED

Often, in hospitals, one finds discord between the executive housekeeper and the chief nurse. This situation is extremely unfortunate and may lead to serious misunderstanding; a lack of esprit de corps among nurses and domestic employes is often the result. Consequently, in the final analysis the patient suffers. If scientific measures, such as an analysis of the job of every worker in the institution, were taken and each worker had a complete understanding of his place within the whole organization, the output of work and the mental attitude of each individual would be vastly improved. The first premise in any job selection is to know the individual and the job in which he is to function.

(*Continued on Page* 129.)

From a paper presented at the Maryland-District of Columbia Hospital Association meeting, November 1947.



Find the CARRIER in this picture!

DON'T LET the crisp white gowns and sterile masks fool you. Every human body is a carrier of treacherous static electricity. And when piled-up static currents seek an outlet, they can ignite anaesthetic vapors and body gases of patients under operation . . . with terrifying results.

Hospitals protect themselves against this hazard with floors designed to drain static electricity from the body, and from operating room equipment. But this protection is often cancelled out by floor maintenance that coats the floors with non-conductive soaps and waxes . . . and robs them of their current-absorbing power.

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This helpful book tells how Legge protects your floors with a highly polished finish that is Non-Slip. How this finish also helps your floors with their static-dissipating job. How a Legge floor technician gives you an upkeep program, tailored to your needs, that actually saves housekeeping dollars.

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In the classification of workers in their own department, nurses have a tendency to evaluate their abilities, habits and skills on the curve of equal distribution comparable to the good and poor workers in every other department. For this reason executives in any department must have a clear understanding of certain attitudes that create dissatisfied employes. All executives within a big plant must have a mutual objective, a friendly feeling toward one another. Our attitude toward our workers must be unbiased at all times. Much can be gained by having a friendly ten minute conference of all department heads each day in order that each may understand the others' problems. Sterile technic, good food and safe nursing care are essential in every case, but the catalyst for the whole patient is his mental attitude, which is largely stimulated through his surroundings.

Hospitals are no longer regarded solely as the abiding place for the ill and injured, but rather as health centers in a community. Health in its broadest sense means the state of complete physical, mental and social well-being, not merely the absence of disease or infirmity.

When she joins the staff of a hospital, the superintendent of nurses need not be too much concerned about certain nursing service assistants if she herself has the proper qualifications, inasmuch as assistants can readily be developed. Her greatest concern should be the policy of the institution in having a carefully selected, adequately prepared, sympathetic and intelligent woman in charge of the general environmental division of the institution. Whether or not the institution has a nursing school does not alter the situation. The fact remains that the executive housekeeper is the key person who sets the artistic and scientific stage in which good professional nursing can function. It is she who is the hospital sanitarian, the household chemist, the interior decorator, the esthetic creator, the institution's "salesman," and the co-therapist.

As an educator I am interested in the scientific knowledge which you trained executive housekeepers are compiling. Your method of approach to your work is no longer "hit and miss." The members of your group are easily distinguished from beginners or amateurs. You acknowledge your mistakes and correct them; there is a common enjoyment of privileges among the members of the National Executive Housekeepers Association, and your work is concerned with human beings. These are essential in the building of a profession.

Soon I hope to hear that you are legislating for state licensure. Your success in this matter will depend entirely upon your own group. Keep insisting on high standards—they are necessary. The nursing profession needs you as teachers for our students. You came to us because we asked you to help us. Let us then, as women, aspire to do a bigger and a better job for our patients. One group alone cannot do it. There must be a unity of purpose, namely the social well-being of the patient. Great is your opportunity; you can make it greater.

In closing I wish to repeat a part of the famous poem "Opportunity" which I think is especially fitting at this time.

They do me wrong who say I come no more
When once I knock and fail to find you in.
Each morn I stand outside your door,
And bid you rise, and fight and win.

NEWS DIGEST

Nursing in Spotlight at Midwinter Meetings . . . Debate "Encroachment" on Medical Practice . . . Plan New Regional Group . . . Klingman Inducted as Wisconsin President . . . Doctors Deplore Specialism . . . Urge More Training Facilities

Nursing Situation Takes Spotlight at A. H. A. Midwinter Conference

CHICAGO. — The advisability of expanding hospital nursing service by the addition of practical nurses, nurse's aides and attendants was the principal subject of discussion during the mid-year conference of state hospital association officers here last month. While the auxiliary nursing service problem was not specifically scheduled for formal talks by any of the speakers, it came up for discussion time and again during the two day conference.

Graham Davis

At the conclusion of the opening session on hospital-nursing relations, for example, Dr. Robin C. Buerki of Philadelphia, chairman of the association's council on professional practice, spoke from the floor questioning the advisability of seeking a solution to current nursing problems through the addition of practical nurses. It was his experience, Dr. Buerki stated, that young girls were not eager to enter this type of service. He also pointed out the difficulties involved in dividing nursing service into professional and nonprofessional tasks.

Answering these objections to the practical nurse solution, Nellie Gorgas, administrator of St. Barnabas Hospital, Minneapolis, declared, "We must have a new labor supply." She said that several Minneapolis hospitals had successfully established practical nurse training programs and had no difficulty recruiting trainees. Especially, Miss Gorgas reported, women in the older age groups had proved responsive to recruitment for practical nurse training.

Following a luncheon meeting on the final day of the conference, President Graham L. Davis asked for an expression of opinion about the use of practical nurses and nurse's aides, and responses from administrators representing all sections of the country indicated that some kind of auxiliary nursing personnel must be trained for hospital service.

Earlier in the program, Dr. Hugo Hullerman, secretary of the association's council on professional practice, stated that the nursing profession today is increasingly characterized by a "philosophy of self interest rather than patient interest." He noted a tendency on the part of nursing leaders to be "aggressive and belligerent" in connection with the security program of the American Nurses Association. The program itself indicates the concern of nurses with their own rather than their

(*Continued on Page* 172.)

Vote No on Meat Allocation

WASHINGTON, D.C.—S.2024 the bill introduced by Senator Flanders for the allocation of meat was voted down by a subcommittee February 3 after public hearings had been held on the measure. S.2023, introduced by Senator Tobey, would authorize the continued exercise of certain limited emergency powers to complete the orderly reconversion of the domestic economy from a wartime to a peacetime basis and to aid in preventing inflationary price increases. This bill asked for the allocation of materials and facilities in short supply at home and abroad.

Seek House Vote on Margarine Bill

WASHINGTON, D.C. — February 2 marked a determined effort to get the oleomargarine repeal bill out of a House committee and onto the House floor for a vote. Senators and representatives who have introduced such tax repeal bills and women's club leaders are back of this new attempt to get the oleomargarine tax repealed. Sparking the drive is Rep. Edward A. Mitchell of Indiana, a veteran, one of the Navy's former underwater demolition men.

Another barrier which Representative Mitchell would remove from the Internal Revenue Code would be exempting hospitalized servicemen and women and veterans from the payment of an admission tax on theater seats given them free. The Red Cross and other organizations have donated thousands of theater tickets to these individuals. But the Red Cross is prohibited from giving anything to veterans for which they have to pay.

The law provides that a tax must be paid on the theater tickets—a provision which cuts many of these hospitalized servicemen and veterans out of a cherished privilege. Mitchell has introduced a bill to repeal section 1700 of the Internal Revenue Code to get around the difficulty.

Named to Advisory Council

WASHINGTON, D.C. — Appointment of two leading men of science to the National Advisory Cancer Council of the National Cancer Institute, U.S. Public Health Service, has been announced by the Federal Security Administration. They are Dr. Edward A. Doisy of St. Louis University School of Medicine and a Nobel Prize winner in Medicine in 1943, and Dr. John J. Morton Jr. of the University of Rochester School of Medicine and Dentistry.

NEWS . . .

Jones and Goin Debate Hospitals' "Encroachment" on Medical Practice

CHICAGO.—A lively debate between Everett W. Jones, vice president of The Modern Hospital Publishing Company, and Dr. Lowell Goin of California featured the annual conference on medical service which preceded the A.M.A. Congress on Medical Education and Licensure here early last month. Mr. Jones and Dr. Goin discussed the alleged "encroachment on the practice of medicine by hospitals."

Mr. Jones declared that court decisions charging hospitals with the corporate practice of medicine do not apply to voluntary hospitals but only to proprietary institutions operated for profit. He questioned the logic of doctors who feel that it is debasing for radiologists, pathologists and other professional men to work as salaried employes of the hospital. "If you think the public is going to look upon you more favorably because you render the bill for these special services yourself, you are being very unrealistic," Mr. Jones declared. Continued insistence on the personal fee basis as a yardstick by which the doctor's dignity and ability are measured will cause thoughtful laymen to lose confidence in the profession, he said.

"Let's be realistic about the patient's personal relations with the radiologist and pathologist," Mr. Jones stated. "Just how often does a patient personally choose his pathologist?" he asked. "How many patients do you think would have any added respect for the pathologist because they received a bill for examination and diagnosis directly from him? How often does the pathologist have personal contact with the patient?

"Yet we all know that a well trained, competent pathologist is literally the keystone of professional standards in the hospital," Mr. Jones concluded. "This specialist should be regarded as one of the most important medical consultants in the hospital and must be the responsible chief of a major department. Hospital trustees and administrators are rapidly realizing this and in most instances understand the need for adequate compensation in one form or another."

Mr. Jones added a warning that the public may begin to class certain elements in the medical profession with arbitrary labor groups unless they refrain from insisting that their specialties be practiced only under conditions considered satisfactory by their own organizations.

"What right have you to tell any free-born American or any ethical, well operated community service hospital under what financial terms it can cooperate in serving the sick?" he asked. Hospital-physician relationships must be built on a solid foundation of mutual respect and understanding, Mr. Jones concluded.

Dr. Goin quoted the report of the Committee on the Cost of Medical Care in support of the claim that hospitals wish to dominate the practice of medicine. He said the inclusive rate plan of rendering bills for hospital service is another example of "hospital domination." The spread of Blue Cross and Blue Shield plans may carry us to socialized medicine, Dr. Goin warned, condemning the inclusion of medical services in Blue Cross contracts. Dr. Goin said court decisions indicate that employment of physicians by hospitals may constitute the practice of medicine by corporations. "Physicians must dictate the policy of hospitals insofar as medical practice is concerned," he said.

In another talk at the medical service conference, Janet Geister, R.N., stated that the practical nurse is here to stay. "She is needed and must and will be accepted," Miss Geister declared.

Lift Margarine Ban

ALBANY, N.Y.—A bill suspending the ban on use of oleomargarine in public institutions in New York State was signed here by Governor Dewey last month. It is estimated that the bill will permit aggregate savings of more than $3,000,000 a year in state institutions. The suspension expires July 1, 1949, under the terms of the bill which does not affect an existing law requiring that butter substitutes be sold uncolored.

Howard Graduates Accepted

WASHINGTON, D.C.—Graduates of Howard University will be accepted as interns and residents at the Gallinger Hospital here beginning next fall, Oscar Ewing, Federal Security Administrator, announced February 17. Howard University now trains about half the nation's yearly output of Negro physicians, Mr. Ewing said.

Veterans Hospital Bills Run Into Opposition

WASHINGTON, D.C.—The House-passed bill to establish a $5,000,000 hospital for Negro veterans at the birthplace of Booker T. Washington in Franklin County, Virginia, ran into stubborn opposition February 4 at a Senate subcommittee hearing. Dr. Magnuson, medical director of the Veterans Administration, and Dr. Hawley, former medical director, both opposed the bill. They argued that if the separate Negro veterans hospital is approved by Congress, it should be located near the Meharry Negro Medical School at Nashville, Tenn.

Walter White, N.A.A.C.P., also testified against the bill. He said that Negroes are opposed to separate hospitals, schools and other institutions. Reminded that Booker T. Washington himself had helped found several all-Negro institutions, Mr. White claimed that if the Negro educator were alive today, he, too, would oppose segregated institutions.

Mrs. Rogers, Congresswoman from Massachusetts, in recommending passage of the bill in the House, had stressed the fact that a Negro hospital completely staffed and managed by Negroes is successfully operated by the Veterans Administration at Tuskegee, Ala. This hospital now cares for more than 2000 Negro veterans. She also called attention to the fact that a 200-bed hospital has been authorized for Negro veterans at Mound Bayou in Mississippi.

Dr. Magnuson and Dr. Hawley opposed the bill providing for the acquisition of the hospital at Camp White, Medford, Ore., for use as a domiciliary facility by V.A.; and the concurrent resolution which called for the taking over of Schick General Hospital at Clinton, Iowa.

$1,000,000 for 100 Beds

LOS ANGELES.—A million dollar campaign for construction of a new 100-bed pavilion for the Cedars of Lebanon Hospital was undertaken here last month. First units to be constructed in the new building will be a power plant and laundry. The new pavilion will include free and part paid beds reserved for patients who cannot afford private care. The maternity department of the new building will be arranged to provide "cornelian" units in which babies can be kept with their mothers.

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NEWS . . .

Hospital Must Protect Employes, Wisconsin Speaker Warns

MILWAUKEE.—Alida Jacobson, administrator of Bellin Memorial Hospital, Green Bay, was named president-elect of the Wisconsin Hospital Association at the annual meeting here February 19. Esther C. Klingman of Clark Memorial Hospital, Neenah, became president for the coming year.

In one of the major addresses of the meeting, B. E. Kuechle of Wausaw, vice president of the Employers Mutual Liability Insurance Company of Wisconsin, condemned hospitals for failing to provide suitable health protection for nurses and other hospital employes. He named fear of illness and especially tuberculosis as an important reason for the nurse shortage. "Parents are discouraging and even prohibiting their daughters from taking up nursing" on account of such fears, Mr. Kuechle declared.

A few hospitals are becoming aware of the danger, the speaker said, but "only because insurance costs are mounting due to compensation claims by hospital employes." While compensation rates for business and industry have dropped approximately one-third in the last fifteen years, Mr. Kuechle pointed out that rates on hospital employes have doubled during the same period.

Esther C. Klingman and Joseph Norby.

A one year course for practical nurses was suggested by Sister Victima of the Holy Family School of Nursing, Manitowoc, at a state conference of Catholic hospitals preceding the association meeting. Such a course, Sister Victima said, would help meet the need for bedside nurses at lower cost to the patient.

Blue Cross and other prepayment plans provide "the only method by which most people will be able to pay hospital bills" in the future because of mounting costs, Dr. Roger DeBusk, administrator of the Evanston Hospital, Evanston, Ill., said in a talk on hospital economics. If it weren't for the prepayment plans, he said, there would be a danger that hospitals will price themselves out of the market for hospital care; however, he added, Blue Cross is not paying hospitals enough in some areas. He advocated a uniform system of cost accounting for hospitals.

In addition to Miss Klingman and Miss Jacobson, other officers elected by the association were: first vice president, Rev. H. M. Schmeuszer, superintendent, Evangelical Deaconess Hospital, Milwaukee; second vice president, Sister Mary Rose, superintendent, St. Mary's Hospital, Milwaukee; treasurer, Stanley Sims, superintendent, Lutheran Hospital, La Crosse, Wis.

NEWS . . .

W.A.A. Expands Donations Program of Surplus Property

WASHINGTON, D.C.—War Assets Administration has announced that its donations program to eligible hospitals and other institutions is being greatly expanded. All items of surplus property, other than real property, will be available for donation after they have been offered for sale to all types of buyers. Moreover, personal property will be donable under the program if its cost of care, handling and disposition would exceed proceeds from its sale.

W.A.A. regional directors may designate personal property for donations to eligible institutions where the total acquisition cost of the items was not in excess of $100,000. W.A.A. zone administrators may approve personal property for this purpose up to $300,000 acquisition cost. But if the original cost exceeds these amounts, approval must come from Washington.

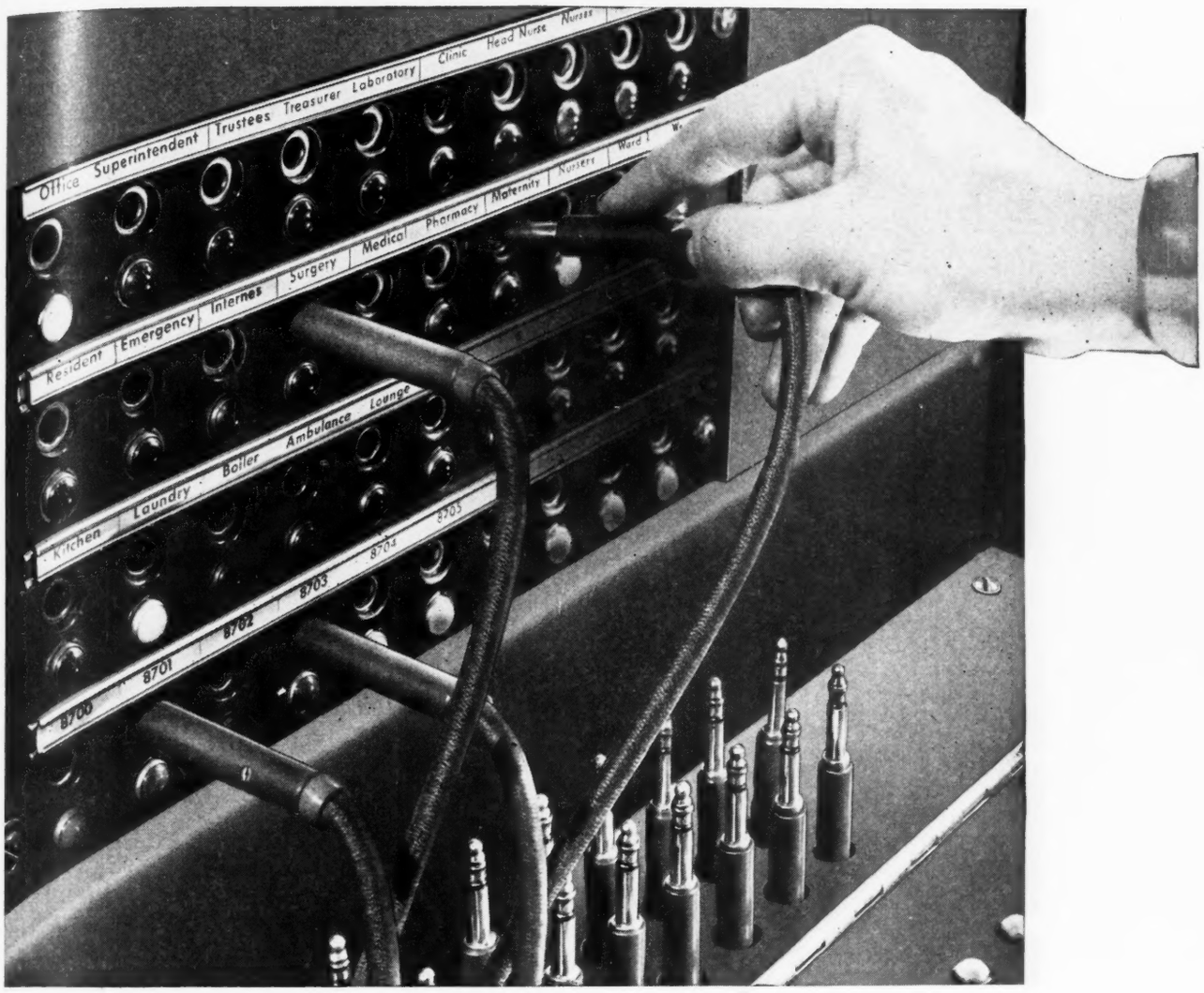
As property is selected for donation in various regions, the regional office will take the initiative in acquainting eligible donees within the region as to what property is available and how to procure it. So far as possible, the program will be coordinated through the established state purchasing organizations representing both public agencies and nonprofit institutions.

A greater quantity and wider variety of surplus property will be available to eligible institutions for operational and training purposes. Surplus machinery of any type which was manufactured during 1921 or any year prior thereto and was not rebuilt since 1921 will be offered to eligible donees prior to offering such property as scrap. Commercially unsalable special machinery listed in W.A.A. Regulation 13, Order 1, will be offered to eligible donees prior to offering it for sale as scrap.

Periods of donation will be of sufficient duration to assure an adequate offering but they will not exceed thirty days.

$1,500,000 Fund Sought

LANCASTER, PA.—A new hospital building costing $2,500,000 is planned for the Lancaster General Hospital. A campaign will be conducted to raise $1,500,000 to complete the building fund and retire present hospital debts, it was announced.



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NEWS . . .

Trend Toward Specialism Deplored By Speakers at A.M.A. Congress

CHICAGO.—If the present trend toward specialism continues unchecked, the future medical welfare of the nation will be seriously threatened, Dr. Wingate M. Johnson of Bowman Gray School of Medicine and North Carolina Baptist Hospital, Winston-Salem, declared at the Congress on Medical Education and Licensure of the American Medical Association here in February.

"It is common knowledge that within the past few years there has been an alarming trend to specialism and away from general practice," Dr. Johnson said. "This trend was given impetus by the war, but it had begun long before Pearl Harbor. Among other responsible factors are the specialty boards, the tendency of many hospitals to close their doors to noncertified men, and the growing popularity of group practice.

"The Council on Medical Education has done its best to encourage the formation of general practice sections in hospital staffs and to discourage hospitals from closing their doors to doctors who are not certified. The approval of the section on general practice, the establishment of the general practitioner's award and many other activities have been for the purpose of encouraging men to enter general practice or to stay in it," Dr. Johnson concluded.

Dr. M. M. Weaver, assistant dean of the University of Minnesota Medical School, also expressed concern over the tendency of young physicians to shy away from general practice. "Opinions obtained from recent medical graduates, physicians who have been in practice for some time, and from hospital administrators agree that a one year rotating internship does not provide sufficient competence for the recent graduate to undertake the major responsibilities of the general practitioner," he said. "The present day residency inclines the recipient toward a restricted medical specialty, and few young doctors can afford to undertake a number of residencies, even if they wished to do so and the residencies were available."

The University of Minnesota Medical School now administers a program of two year internships for general practice, Dr. Weaver explained.

The desperate financial situation of many American medical schools is in large part due to a national shortage of multimillionaires, Alan Valentine, president of the University of Rochester, told another meeting of the congress. Medical schools need about $40,000,000 more per year, President Valentine said.

Present endowments possessed by medical education have come chiefly from two sources, philanthropic foundations and multimillionaires, he added. "Occasional gifts and bequests of several millions of dollars are still coming to universities, and there are still more multimillionaires than is generally known," he said, "but they must be found; they must be reached; they must be educated to giving largely to medical education."

The successful results obtained in the Veterans Administration medical rehabilitation service have shown the

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necessity for a similar civilian program, Dr. Howard A. Rusk of the New York University College of Medicine declared in an address to the congress. As typical of these results he mentioned a study of 130 chronic neurological patients in one hospital, all but two of whom were veterans of the first world war and many of whom had not been out of bed in ten years.

"After nine months of medical rehabilitation," he reported, "twenty-five had left the hospital and were employed, forty others had been discharged to their homes capable of light work, and of those remaining, thirty were ambulatory and undergoing advanced rehabilitation and twenty-five were capable of self care. All but ten of the group had shown some worthwhile permanent improvement. With a five year life expectancy of these patients and a per patient day hospitalization cost of more than $12, rehabilitation of this one group has saved the government, and eventually the taxpayer, more than $1,250,000."

Dr. Rusk said that with these results in mind, "the first comprehensive total medical rehabilitation program in any community hospital in this country has recently been inaugurated at Bellevue Hospital in New York. The service has bed facilities for eighty patients and offers a program of physical medicine, physical therapy, occupational therapy, corrective physical rehabilitation, social service, corrective speech, psychological services, vocational guidance, education and planned recreation. It operates as a service department to the other departments of the hospital in much the same manner as do the x-ray department and laboratory, and treats both inpatients and outpatients on reference from the other services of the hospital.

"The rehabilitation service in Bellevue Hospital, which will be enlarged to 600 beds when presently planned construction is completed, is the first step in a plan by the department of hospitals of the city of New York to provide all patients in municipal hospitals of the city with medical rehabilitation services.

"The interest in extending medical rehabilitation services in general hospitals is not limited to New York or other large urban areas. The Veterans Administration has recently established such services as major departments with specified bed allocations in all Veterans Administration hospitals."

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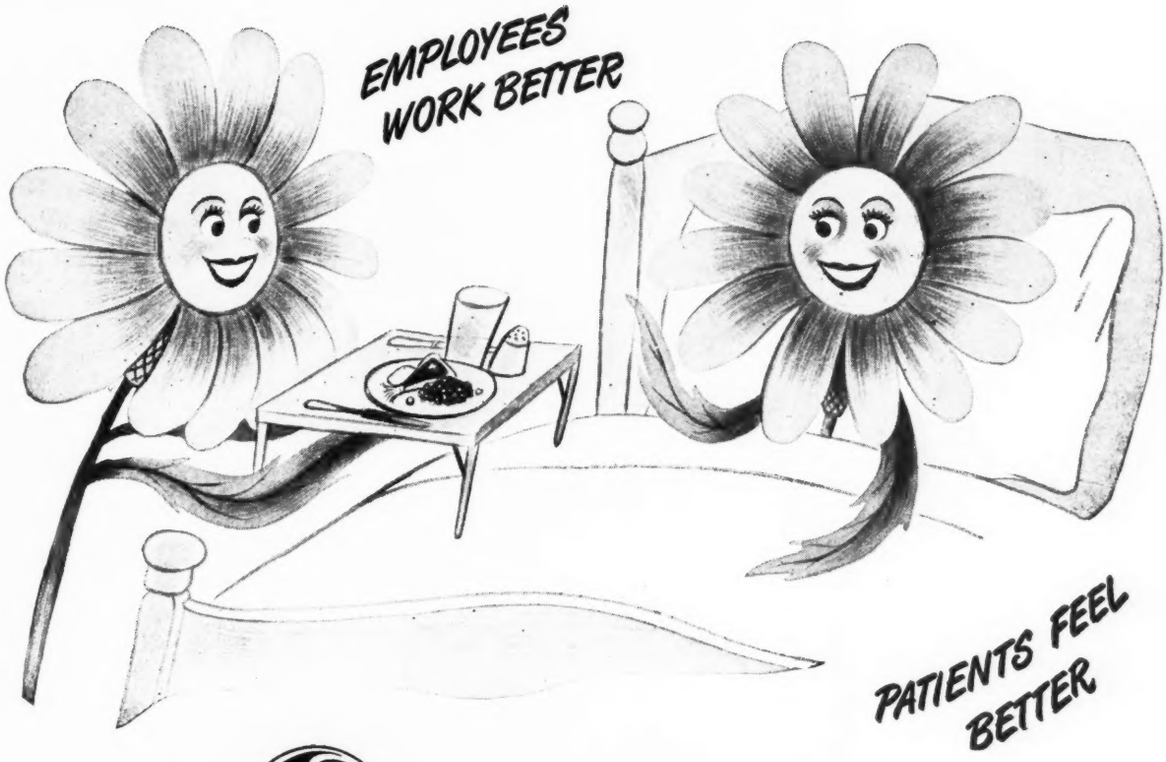

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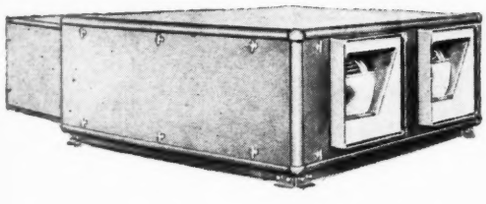

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NEWS . . .

Report Scores Shortage of Training Facilities for M.D.'s, Nurses

By EVA ADAMS CROSS

WASHINGTON, D.C.—"Shortages of professional personnel to take care of the health needs of the nation must be of serious concern to institutions of higher education," the President's Commission on Higher Education said in a recent report. The Commission took into account the high cost of medical, dental, nursing and pharmaceutical education, but it pointed out that the estimated $500,000,000 cost to the nation of institutional service as the result of lack of health care was far greater.

The shortage of doctors is serious and will grow worse, the report warned. By 1960, merely on the basis of current demand, the deficit will be at least 26,000. And that is not all. If the actual and urgent need for better services, such as for general practitioners in local communities, is included, the shortage is increased by an additional 30,000. The achievement of adequate medical care will require a substantial increase in the output of our medical schools over a long period of years.

As to nurse shortage, the President's commission pointed out there is already a national deficit of some 41,700—this, in spite of federal subsidy for training of nurses during the war. It is estimated that the minimum demand for registered nurses in 1960 will be 554,200. Even if the number of graduates in nursing could be held to the wartime peak of 45,000 a year, there would still be a serious shortage of nurses in 1960, the commission predicted darkly. It urged active recruitment of students in this field.

Summing up this phase of its report, the Commission on Higher Education emphasized that the expansion of physical facilities and their maximum use in medical, dental, nursing and pharmaceutical education should not be delayed. The training of many more medical, dental, and laboratory technicians will also help considerably to relieve the existing and prospective shortages in these professional fields.

The Commission struck at racial discrimination as practiced in professional schools, particularly in medical schools. With such constrictions upon the professional education of Negroes, the present production of Negro physicians cannot keep pace even with the growth of the Negro population, much less contribute to the general need. This shortage of doctors, serious for the white population, is a near catastrophe for the health of the Negro population. And, the report added, discrimination by educational institutions is a contributing factor to it.

The report called attention to the fact that of the 77 medical schools in the nation, 20 are located in the South and do not admit Negroes; the remaining 55 are presumably open to Negroes. Actually, however, continued the report, only one-third of the presumably nonsegregated schools are admitting Negro students. In 1946, of the estimated 592 Negro medical students, 85 were enrolled in 20 nonsegregated schools; the remainder were enrolled in the only two Negro medical schools in the country—Howard University and Meharry Medical College.

Because of staff and plant limitations, these two Negro medical colleges cannot begin to train the Negroes who desire

NEWS . . .

and who are qualified for careers in medicine, said the Commission. Howard University Medical School can now accept seventy-five students in its freshman class. Yet, in 1946-47, there were 1350 applicants.

The commission put the finger on tax-supported and other hospitals for the practice of barring Negro students from clinical facilities. Internship and residency in a hospital are educational requirements for a career in medicine and they constitute additional areas where discrimination exists—a major factor limiting the training of Negro doctors. The Negro student must train only in Negro hospitals. There are only about 112 such hospitals in the United States. Of these schools, twenty-five are accredited and only fourteen are approved for the training of interns.

The Commission did not rest its case with the indictment of medical schools. It took up the matter of discrimination in nursing schools also. Of a total of 1280 nursing schools in the country, twenty-eight admit Negroes only, thirty-eight admit Negro and white students, and the remaining 1214 are for whites only.

Religious discrimination in medical schools likewise came in for attention from the President's commission. It used facts and figures to show blocking of opportunity to Jews in medicine. The commission conceded that a substantial part of the blame for discriminatory practices on the part of the medical and dental schools belongs to the professional associations which tremendously influence the admissions policy of individual institutions.

The report made special mention of the restrictive admissions policies of certain professional schools. "Some professional associations, which have assumed heavy responsibilities for accrediting professional schools, have become too restrictive in the number of students they allow to be admitted. Such arbitrary limitations create a monopoly and do not provide sufficient practitioners to meet the national demand. An insistence on high qualitative standards may thus be made the means of too drastic quantitative curtailment."

Committee on Practical Nursing Set Up by Ohio Nursing League

COLUMBUS, OHIO.—A committee on practical nursing has been set up by the Ohio League of Nursing Education, it was announced last month. Mrs. Marion A. Fluent, director of nursing service, University Hospital, Cleveland, is chairman. Relief for professional nurses is to be sought through the training of practical nurses, it was explained.

Announcement of the proposed practical nurse education program was made in Columbus by Frances McKenna, director of Ohio State University School of Nursing. Contacts have been made with the state board of education, she said, and possibilities have been explored of financial help through vocational education on the adult level.

A practical nurse, as defined by the U.S. Office of Education, is a person trained to care for "subacute, convalescent and chronic patients," and who works "under the direction of a licensed physician or a registered professional nurse, and who is prepared to give household assistance when necessary," Miss McKenna said.

NEWS . . .

List Additional Applications Under Public Law 725

WASHINGTON, D.C.—Initial applications for construction of 123 hospitals were approved under Public Law 725 up to February 13, the Hospital Facilities Division, U.S. Public Health Service, reported. Estimated total cost of the approved hospitals is $62,375,514, of which $19,466,339 is to be the estimated federal share.

In addition to those previously listed in The MODERN HOSPITAL, hospitals for which initial project applications have now been approved include the following:

Alabama: Druid City Hospital, Tuscaloosa. *Arkansas:* Crossett Health Foundation, Crossett; Boone County Hospital, Harrison; Clark County Hospital, Arkadelphia; Cross County Hospital, Wynne; Crittenden County Hospital, West Memphis. *Florida:* Southeast Florida Sanatorium, Lantana; Bay County Hospital, Panama City. *Georgia:* Carrollton General Hospital, Carrollton. *Indiana:* Hancock County Memorial Hospital, Greenfield. *Kentucky:* Bowling Green Hospital, Bowling Green; Caldwell County Memorial Hospital, Princeton; Clinton and Hickman County Hospital, Clinton. *Massachusetts:* Glover Memorial Hospital, Needham.

Mississippi: Washington County Health Center, Greenville; Scott County Hospital, Forrest; Lamar County Public Health Center, Purvis. *New Mexico:* Dona Ana City-County Hospital, Las Cruces. *Oklahoma:* Edwards Memorial Hospital, Oklahoma City. *Oregon:* Tillamook County Hospital, Tillamook. *South Dakota:* Rosebud Community Hospital, Winner. *Tennessee:* Blount Memorial Hospital, Maryville; Carroll County Hospital, Huntington; Madison County Hospital, Jackson; East Tennessee Tuberculosis Hospital, Knoxville; Mental Hospital, Knoxville; Tuberculosis Hospital, Chattanooga; Obion County Hospital, Union City; Lauderdale County Hospital, Ripley.

Texas: Moore County Memorial Hospital, Dumas; Clay County Memorial Hospital, Henrietta; Hemphill County Hospital, Canadian; Panola County Hospital, Carthage; Hudspeth Memorial Hospital, Sonora; Midland Memorial Hospital, Midland. *Washington:* Franklin County Health Center, Pasco.

Rural Health Leaders Meet

CHICAGO.—Health problems of the rural child highlighted the third annual national conference on rural health here last month. More than 500 leaders in child health and welfare work throughout the country, representatives of farm groups, the medical profession and others attended the two day meeting, sponsored by the committee on rural medical service of the American Medical Association in cooperation with the American Academy of Pediatrics and representative farm organizations.

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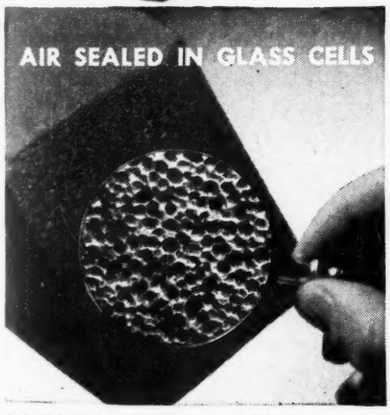

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NEWS . . .

I.H.A. Speakers Weigh Auxiliary Nurses as Solution to Shortage

SPRINGFIELD, ILL.—"I want a graduate nurse to give me hypodermic injections and to hand instruments to the surgeon when I am in the operating room but I don't care who arranges the flowers and makes my bed when I am a patient," Dr. Roger W. DeBusk, executive director of the Evanston Hospital and president of the Chicago Hospital Council, declared in a discussion of the nursing problem at the Illinois State Hospital Association conference here last month. Dr. DeBusk and Everett W. Jones, vice president of The Modern Hospital Publishing Company, said that some auxiliary nursing personnel must be used in the hospital, while other speakers doubted that the answer to nursing service difficulties could be found in this direction.

In another talk at the conference, George Bugbee, director of the American Hospital Association, said that a diminished demand for expensive private rooms was reported from various parts of the country and that collections are tightening up. Obstetrical department occupancies are beginning to decline in some areas, Mr. Bugbee added. He predicted another round of wage increases in all industries and consequently in hospitals, quoting hospital financial authorities as predicting a 20 to 30 per cent increase in hospital costs during the next year or two.

Hospitals must not hesitate to raise rates "early enough and high enough," Mr. Bugbee said. Nevertheless, he urged executives to study every detail of hospital operation in an effort to effect operating economies.

Myrtle McAhren, administrator of the Blessing Hospital, Quincy, and Dr. DeBusk were named Illinois delegates to the American Hospital Association and Mabel Binner, Children's Memorial Hospital, Chicago, and J. T. Tollefson, Lutheran Hospital, Moline, were elected alternates.

Roosevelt Hospital Designated Part of N.Y. Master Plan

NEW YORK.—The Hospital Council of Greater New York has designated Roosevelt Hospital as a participating hospital in its Master Plan, a guide for the integration and development of hospital and health facilities in relation to the needs of the people, it was announced in the council *Bulletin* last month.

The review of the program at Roosevelt Hospital revealed that the hospital plans replacement facilities for the reception and emergency departments, and also for the outpatient department. In addition, the hospital plans to establish facilities for a maternity service, which the council has stressed as necessary in every general hospital. Extensive rehabilitation of facilities has been in progress during the last eight years. The size of the hospital, the report added, will not exceed 600 beds.

The council, the *Bulletin* explained, is now in a position to review the plans and programs of hospitals presenting them for interpretation in relation to the Master Plan, and to designate as "participating hospitals" those hospitals whose activities are consistent with the plan's basic principles.

NEWS . . .

Hingson, U.S.P.H.S. Surgeon, Honored by Junior C. of C.

WASHINGTON, D.C.—The U.S. Public Health Service pointed with pride January 26 to the choice of Surgeon R. A. Hingson by the Junior Chamber of Commerce of the United States as one of the ten outstanding young men of the nation in 1947. A gold key, token of the honor, was presented at ceremonies in Chattanooga, Tenn.

Among other things, the young medical officer won acclaim for his part in developing the method of continuous caudal analgesia for the control of pain in childbirth, and in the treatment of eclampsia, thrombophlebitis, and peripheral vascular disease; also for the hypospray technic used for parenteral injections. His method of continuous caudal analgesia is now widely employed, and during the last eight years, Dr. Hingson has conducted training classes attended by more than 1500 physicians throughout the United States and a number of foreign countries.

Last year Dr. Hingson was the first physician to use the hypospray as a substitute for the needle in therapy.

Dr. Hingson is currently detailed by the U.S. Public Health Service to the University of Tennessee's College of Medicine in Memphis. He is co-director there of the postgraduate course in anesthesiology and obstetrics.

Jubilee Meeting of New England Group To Draw 3000

BOSTON.—The silver jubilee meeting of the New England Hospital Assembly, March 15-17, is expected to bring more than 3000 hospital executives, trustees and staff members to Boston for a three day conference covering all phases of hospital planning, construction and operation, according to a preliminary announcement released by Paul J. Spencer of Lowell, Mass., assembly secretary.

Major topics for discussion in the general assembly are the Hospital Construction Act, community relations and nurse recruitment, and contract payment for hospital service. An all day institute for hospital trustees will again be an outstanding feature of the assembly as it was last year. The preliminary program for the meeting features tricky titles for the various assemblies; for example, a program on hospital construction and Public Law 725 is billed "The House That Jack Built."

Members of the program committee for the assembly are Dr. Albert Engelbach of Mount Auburn Hospital, Cambridge, chairman; Louette MacLeod, Camden, Me.; Laurence C. Campbell, Barre, Vt.; Dr. Gerald F. Houser, Jamaica Plain, Mass.; William J. Donnelly, Greenwich, Conn.; Carl A. Lindblad, Providence, R.I.; Lois A. Bliss, Franklin, N.H.

Elect New Orleans Officers

NEW ORLEANS.—Joseph W. Hinsley, assistant director of Touro Infirmary, was reelected president of the New Orleans Hospital Council last month. Other officers named were Dr. E. H. Carnes of the U.S. Marine Hospital, vice president, and John F. Screen, public relations officer of Hotel Dieu, secretary-treasurer.

NEWS . . .

Three State Groups Form Middle Atlantic Hospital Conference

NEW YORK.—State hospital associations of New York, Pennsylvania and New Jersey have joined together in forming the Middle Atlantic Hospital Conference, officers of the associations announced last month. The conference will hold a three day meeting annually in May at Atlantic City, N.J., the announcement said. The first meeting will be held in 1949.

Trustees of the Maryland-District of Columbia Hospital Association voted against joining the Middle Atlantic Conference at the present time, it was announced but it is expected that the Delaware Association may become a part of the conference.

The board of trustees of the conference will include three representatives from each of the participating state hospital associations, it was explained. Although the conference will eliminate the annual conventions now held by each of the state associations, provision is made for each state which desires to do so to hold its own annual meeting during the regional convention.

Present presidents of the associations joining in the Middle Atlantic Conference are: New Jersey, George H. Buck, Mercer Hospital, Trenton; New York, Dr. Morris Hinenburg, Jewish Hospital, Brooklyn; Pennsylvania, N. J. Sepp, Western Pennsylvania Hospital, Pittsburgh.

M.R.L.'s Plan Courses

CHICAGO.—The American Association of Medical Record Librarians has announced its schedule of extension courses planned to give untrained workers an opportunity to learn the basic principles and skills needed for medical record departments. Several types of courses are being offered so record personnel may select those which will best fit their needs. Three types have been planned, a two weeks' basic course for beginners, a one week regular course as previously given, and an advanced course or workshop.

The following programs are definitely scheduled: February 16-20, Salt Lake City, Utah, regular; March 29-April 2, Tulsa, Okla., regular; April 5-16, Houston, Tex., beginners; May 24-28, Denver, advanced.

NEWS . . .

U. of Iowa Approves Nurse Training Course on Three Levels

IOWA CITY, IOWA.—A new plan for the school of nursing at the State University of Iowa has been approved, Dean Carlyle Jacobsen of the division of health sciences and services, announced recently. Under the new plan it will be possible to add instructors and assistant professors whose primary responsibility will be the instruction of students; these teachers will not divide their time and attention between instructional duties and the rendering of service to patients, it was explained.

It is contemplated that the school of nursing will offer training at three levels:

1. A three year curriculum open to high school graduates, which will lead to a certificate of graduate nurse (Registered Nurse).

2. A program combining study in the College of Liberal Arts and in the school of nursing, leading to a professional degree in nursing (Bachelor of Science in Nursing). This course will require between four and five years.

3. A series of postgraduate courses in several specialized areas of nursing service, such as public health nursing; psychiatric, orthopedic, obstetric and pediatric nursing; and in conjunction with the graduate college and the college of education, training in the fields of nursing service, administration and education. It is thought that some postgraduate students will wish to plan studies leading to a master's degree.

The school of nursing will continue to place major emphasis on training of bedside nurses while developing the more advanced curriculums for nursing specialists.

Omaha Council Revises Name and By-Laws

OMAHA, NEB.—At its annual meeting here last month, the Omaha Hospital Council voted for revision of its constitution and by-laws to create an executive committee made up of the officers, the immediate past president and one member elected by the council. The revised by-laws also provide a new name for the organization, the Omaha Area Hospital Council, to allow expansion within a radius of from 50 to 75 miles.

The following new officers were elected for 1948: president, Dr. Harold C. Lueth, dean of the college of medicine, University of Nebraska; president-elect, Hal G. Perrin, administrator, Bishop Clarkson Memorial Hospital; secretary, John E. Lowry, business manager, Immanuel Hospital, and treasurer, Sister Mary Kevin, director of the school of nursing, St. Catherine's Hospital.

No Increase for Interns

WASHINGTON, D.C.—Interns and residents receiving government living allowances under the G.I. Bill of Rights do not benefit from the higher rates for veterans in school granted by Congress last month. The old rates of $65 a month for veterans without dependents and $90 a month for veterans with dependents will remain in effect for internship and residency training, a Veteran Administration spokesman declared. The old rates will also prevail for all allowances granted to veterans in part time institutional training, it was explained.

NEWS . . .

Rochester Hospitals Launch Two Year Expansion Program

ROCHESTER, N.Y.—A program to raise $6,940,000 in Rochester and Monroe County to construct a new hospital on the north side of the city and enlarge five existing hospitals is in progress under the auspices of the Rochester Hospital Fund, Inc. The fund was organized as a central agency for financing and coordination following a community-wide study of hospital expansion needs by a civic committee on hospital facilities.

The new north side hospital is to be administered by Rochester General Hospital, whose present buildings will be converted in part for the use of chronic disease patients. Genesee, Highland and Park Avenue hospitals will undergo enlargement and modernization, a new outpatient department will be constructed at St. Mary's Hospital, and Strong Memorial Hospital will add a six story wing for growing clinical services now inadequately housed.

Besides replacing an estimated 135 acute beds in structures marked for dismantlement, the project contemplates the addition of at least 400 beds, along with new facilities, including one or more diagnostic clinics for private patients. An overall objective is to increase accommodations for the acutely ill in Monroe County by 20 per cent. To accomplish all these objectives, public subscriptions are to be sought over a two year period.

Fund raising counsel for the joint program is Will, Folsom and Smith, Inc., of New York and Boston.

Federal Aid Essential for Medical Schools, Ewing Asserts

NEW YORK.—Federal aid for medical education is essential to prevent a public health crisis which may develop from the shortage of trained medical personnel, Oscar R. Ewing, Federal Security Administrator, declared at the annual meeting of the National Health Council here last month.

Mr. Ewing said that outright grants of as much as $100,000 a year to help pay medical school operating expenses, and grants of as much as 50 per cent of the cost of necessary plant expansion are essential in order to ensure the supply of doctors necessary for the health and well being of the American people. He also advocates 1200 scholarships for medical students.

Unless these measures are adopted, Mr. Ewing said, there will be a shortage of between 15,000 and 30,000 doctors in the United States by 1960. "I am convinced that federal aid to medical students and to medical schools is essential," Mr. Ewing concluded.

Joins Consulting Staff

CHICAGO.—Walter J. Mezger has become associated with Herman Smith, M.D., hospital consultant, it was announced here last month. Mr. Mezger was associate director of Michael Reese Hospital, Chicago, for twelve years during the time Dr. Smith was director of the hospital. He also was director of the Knickerbocker Hospital in New York City and the Cedars of Lebanon Hospital, Los Angeles.

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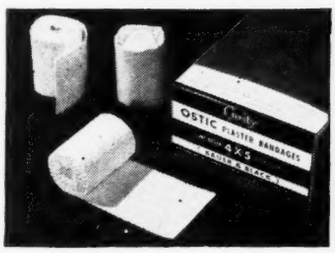
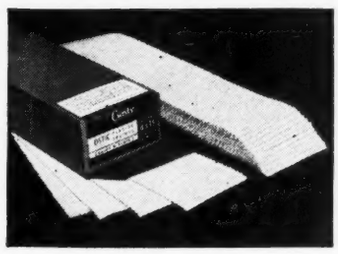
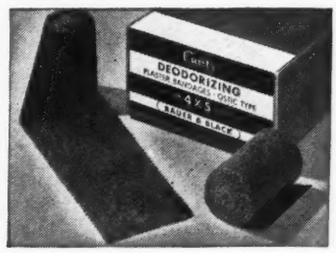
**Monro, J. K.: The History of Plaster-of-Paris in the Treatment of Fractures. British J. Surgery, 23(90): 257-266 (October), 1935.*







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NEWS . . .

Mental Health Group Honors Psychiatric Aide

PHILADELPHIA.—Walter Starnes, a psychiatric aide at the Veterans Administration Winter Hospital, Topeka, Kan., was named the first recipient of the newly established National Mental Health Foundation "Psychiatric Aide of the Year" Award, it was announced last month by Harold Barton, executive secretary of the foundation. The award was established last year as part of the foundation's campaign to encourage the adoption of higher standards of care in mental hospitals.

Commenting on the award, Dr. Karl A. Menninger, manager of Winter Veterans Administration Hospital, stated: "Walter Starnes is an ambassador extraordinary. The qualities for which he was chosen—kindness, tact, sensitivity to the needs and feelings of others, patience, humility and, above all, character—could very well make Starnes the outstanding man of the year."

COMING MEETINGS

AMERICAN DIETETIC ASSOCIATION, Hotel Statler, Boston, Oct. 18-22.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Traymore Hotel, Atlantic City, Sept. 19, 20.

AMERICAN HOSPITAL ASSOCIATION, Traymore Hotel, Atlantic City, Sept. 20-24.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Hotel Pennsylvania, New York City, Sept. 7-9.

AMERICAN PHYSICAL THERAPY ASSOCIATION, LaSalle Hotel, Chicago, May 23-28.

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 19-22.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Roanoke Hotel, Roanoke, Va., April 15, 16.

CATHOLIC HOSPITAL ASSOCIATION, Cleveland Public Auditorium, Cleveland, June 7-10.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Bellevue-Stratford Hotel, Philadelphia, April 28-30.

IOWA HOSPITAL ASSOCIATION, Hotel Fort Des Moines, Des Moines, April 24.

MARYLAND-DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION, Statler Hotel, Washington, D. C., Nov. 8, 9.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Wade Park Manor, Cleveland, May 3-5.

NATIONAL EXECUTIVE HOUSEKEEPERS' ASSOCIATION, Brown-Palace Hotel, Denver, June 23-26.

NEW JERSEY HOSPITAL ASSOCIATION, Hotel Dennis, Atlantic City, N. J., May 20-22.

OHIO HOSPITAL ASSOCIATION, Deshler-Wallick Hotel, Columbus, April 6-8.

SOUTHEASTERN HOSPITAL ASSOCIATION, Biloxi, Miss., April 22-24.

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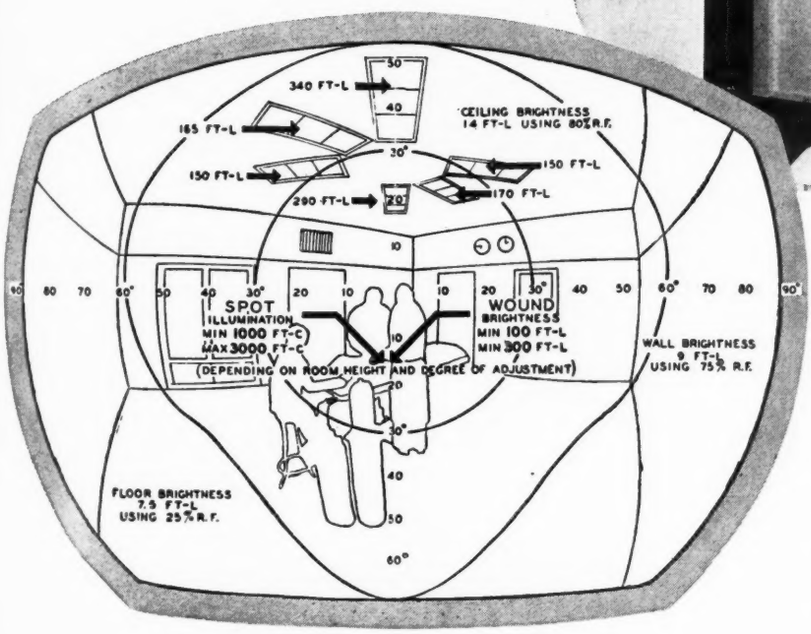

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NEWS . . .

Children's Hospital, Portland, Me., Closed for Lack of Funds

PORTLAND, ME.—The Children's Hospital here has been closed because of continued financial difficulties and patients have been transferred to the Maine General Hospital, Owen M. Smith, president of the Children's Hospital board of managers, and Robert Braun, president of the board of directors of the Maine General, announced jointly last month. Plans for disposal of Children's Hospital building, which has been abandoned for hospital purposes, were not complete, Mr. Smith said.

Children's Hospital will, however, continue its corporate identity operating within the Maine General structure, it was explained. "The greater part of both the professional and administrative staffs will continue to be associated with the two organizations," Mr. Smith said. "The hospital will continue to maintain its efforts in providing the best child care possible."

Decision to close the Children's Hospital was made by the board of managers after long deliberation, it was reported, because three-quarters of the hospital's patients are state aid or charity cases for whom payments have been nearly $3 per patient day less than operating costs.

18 N.U. Students Given Internships

CHICAGO.—The Northwestern University program in hospital administration has announced internship appointments for eighteen students who completed their academic work during the past semester. The appointments are: Hayden M. Deaner, George F. Geisinger Memorial Hospital, Danville, Pa.; John A. Schaffer, Reading Hospital, Reading, Pa.; John B. Hughes and Mary Ann Gilster, Evanston Hospital, Evanston, Ill.; Charles E. Mattix, Grace Hospital, Detroit; Taylor O. Braswell, W. K. Kellogg Foundation, Battle Creek, Mich.; George B. Pearson, Harris Memorial Methodist Hospital, Fort Worth, Tex.; Thomas B. Sellers, Hermann Hospital, Houston, Tex.

David K. Huffman, Baylor University Hospital, Dallas, Tex.; Mildred L. Recknagel, six months at City Hospital, Springfield, Ohio, and six months at Woodrow Wilson Rehabilitation Center, Fisherville, Va.; Manley C. Solheim, Charles B. Wilson Memorial Hospital, Johnson City, N. Y.; James A. Robinson, Los Angeles County General, Calif.

Jack Hahn, Fremont Hospital, Fremont, Ohio; Robert A. Bradburn, Columbus Hospital, Milwaukee; Robert W. Wencil, Wesley Memorial Hospital, Chicago; Sylvester J. Schroeder, Michael Reese, Chicago. Edwin H. Prescott is awaiting an appointment as administrative assistant.

Offers In-Service Courses

DETROIT.—Wayne University College of Nursing has arranged a series of short courses for in-service nurses and nurse executives, it was announced here. The series is designed primarily to improve the quality of nursing service and education in the state and includes programs on medical and surgical nursing, obstetrical nursing, child growth and development, and public health and industrial nursing.

NEWS . . .

A.H.A. to Hold Two Institutes on Dietary Departments in April

CHICAGO. — Institutes on hospital dietary departments will be held in Buck Hill Falls, Pa., April 19-23 and in Kansas City, Mo., April 12-13, the American Hospital Association has announced. The institutes are designed to help administrators work closely with their dietitians in establishing sound and efficient departmental organization with resultant attractive, well-planned meals for patients.

The institute in Pennsylvania is sponsored by the Hospital Council of Philadelphia, Hospital Association of New York State, Greater New York Dietetic Association, Philadelphia Dietetic Association and Teachers College, Columbia University. Scheduled for administrators and dietitians attending the Mid-West Hospital Association meeting, the Kansas City institute is sponsored by the Mid-West association, Kansas City Area Hospital Council, Kansas City Dietetic Association and the Kansas Dietetic Association.

Southeast Pharmacists Meet in Atlanta

ATLANTA, GA. — Forty-one hospital pharmacists from seven states met here last month for the second semi-annual meeting of the Southeastern Hospital Pharmacy Association. The program included a field trip through Emory University Hospital.

Paul T. Rees, special representative of Bristol Laboratories, Washington, D. C., spoke on the National Red Cross Blood Program. He said that in areas where no hospitals were located, but where pharmacists were available, the pharmacists would be the logical persons to administer the program. In addition, small hospitals with no laboratories and no complete pharmacy, which were served by one part time pharmacist, might logically place the blood program in the hands of the pharmacist.

Guy Trimble, member of the staff of the Hospital Facilities Division, U.S. Public Health Service, outlined the place for hospital pharmacy in the hospital building program now under way. Present plans call for pharmacists in all hospitals of more than 100 beds. Hospitals under 100 beds will have a drug room where simple compounding may be done.

Propose Blue Shield Program for Chicago

CHICAGO.—A Blue Shield plan affording prepayment of doctors' bills for hospitalized illness was announced for Chicago last month by Edson P. Lichty, executive director of the Blue Cross Plan for Hospital Care, which has arranged with the Chicago Medical Society to administer the medical prepayment program.

According to the announcement, which indicated that the plan would not be available for several months, the membership fee will be $1 a month for a single member and $2.50 for a family.

A majority of the Chicago Medical Society's 8000 members has agreed to the proposed contract, Mr. Lichty said. The plan will provide full service benefits for low income families and doctors will be permitted to make additional charges to patients in the higher income group, it was explained.

NEWS . . .

Reclaim Gauze to Prevent Shortage, Hospitals Warned

NEW YORK.—The shortage of surgical gauze may develop quickly to a point where hospitals will be handicapped in rendering service to patients, the Hospital Bureau of Standards and Supplies warned in a bulletin last month. Major suppliers have already reduced gauze allotments 25 per cent, the bureau said, and reductions of as much as 50 per cent may follow.

The shortage was attributed to the fact that several independent mills have converted to production of print cloths, a more profitable item.

Answering an inquiry from the bureau, Secretary of Commerce Harriman said the shortage would be among the supply problems to be discussed with industry representatives. "In these discussions, surgical gauze will be among the subjects presented to the industry for consideration," Secretary Harriman declared.

In order to conserve gauze during the period of the shortage, the bureau recommended that hospitals develop technics for reclaiming gauze bandages. "Discarding dressings after one use represents a tremendous waste," the bulletin said. Massachusetts General Hospital was reported to have reclaimed 16,000 pounds of gauze in 1947.

New York Hospitals To Receive $1,000,000 Extra from Blue Cross

NEW YORK. — Associated Hospital Service will grant an additional payment of $1,000,000 for the care of Blue Cross patients during the first four months of 1948, it was announced in February by Louis H. Pink, president. The extra payment, approved by the state departments of insurance and social welfare, is the second granted to hospitals in recent months. Last November, hospitals were paid an additional $1,300,000 to meet increased costs during 1947.

Pointing out that the loss of approximately $14,000,000 now incurred by voluntary hospitals in New York City is largely due to free or part free services, Mr. Pink stressed the need for immediate state aid to voluntary as well as public hospitals and increased payments from the city for indigent cases.

CENTRAL MICHIGAN COMMUNITY HOSPITAL, Mount Pleasant, Michigan. J. Walter Leonard, Chairman, Hospital Board. Built 1942. Architect: James Gamble Rogers, Inc., New York. Consulting Engineer: Jaros, Baum & Bolles, New York. Heating Contractor: A. W. Eurich, Bay City, Michigan.

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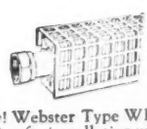


New! Webster Type WI Radiation for installation where floor or wall space is limited.

NEWS . . .

Ewing Calls Assembly to Work Out Ten Year Health Program

BY EVA ADAMS CROSS

WASHINGTON, D.C.—To work out a ten-year program of health a National Health Assembly has been called to meet here May 1 to 4 by Oscar R. Ewing, Federal Security Administrator. Set up at the instance of President Truman, the assembly will consist of representatives of public and private organizations and agencies concerned with the nation's health. A twenty-four-member executive committee will be made up of national leaders in various fields.

Declaring his zeal toward bettering the health of the country to be as vigorous as that of a new convert, Mr. Ewing brushed aside the skepticism of certain members of the press and asserted that the projected National Health Assembly can be of tremendous benefit. It would not be "just another conference" but a working group with spokesmen from the medical and health professions, from voluntary health organizations, and from the citizens generally.

The assembly's activity will take the form of panel discussions, each panel to explore fully a specific phase of the health problem. "This assembly will spring from and its results go back to the 'grass roots' of the country," Mr. Ewing maintained. There will be definite follow-up of the conference's conclusions and recommendations.

Instead of concentrating on fights in controversial health fields, national health leaders will work together in "areas of agreement"—research, medical education, training of health personnel, child and maternal health and school health education.

The immediate benefits to come out of the assembly, as Mr. Ewing sees it will be:

1. A guide to community action for local health improvement.
2. A detailed practical pattern of cooperation among all organizations operating in the health field, *i.e.* public and private, national, state and local.
3. A more detailed and specific knowledge of our present health picture and of the job that has to be done to improve it.

Members of the executive committee, National Health Assembly, as of February 13, are the following.

Barry Bingham, editor and president, *Louisville Courier-Journal;* Mrs. J. L. Blair Buck, president, General Federation of Women's Clubs; Earl Bunting, president, National Association of Manufacturers; Elisabeth Christman, secretary-treasurer, National Women's Trade Union League; Dr. Louis I. Dublin, second vice president and statistician, Metropolitan Life Insurance Company; Judge Jerome N. Frank, U.S. Circuit Court of Appeals; Albert S. Goss, president, National Grange; William Green, president, American Federation of Labor; Most Rev. Francis J. Haas, Bishop of Grand Rapids, Grand Rapids, Mich.; Frieda Hennock, New York City; Mrs. L. W. Hughes, president, National Congress of Parents and Teachers; Eric Johnston, president, Motion Picture Producers and Distributors of America; Allan Kline, president, American Farm Bureau Federation; Mrs. Mary Lasker, New York City; Mrs. David Levy, New York City; Dr. George F. Lull, secretary and general manager, American Medical Association; Mrs. Eugene Meyer, Washington, D.C.; Philip Murray, president, Congress of Industrial Organizations; Mrs. Anna M. Rosenberg, New York City; Earl O. Shreve, president, U.S. Chamber of Commerce; Dr. Frank Stanton, president, Columbia Broadcasting System, Inc.; M. W. Thatcher, president, National Federation of Grain Cooperatives; Walter White, secretary, National Association for the Advancement of Colored People; Dr. Abel Wolman, consulting engineer, Johns Hopkins University.

NEWS . . .

89 Per Cent of British Doctors Vote Against National Health Act

CHICAGO.—Eighty-nine per cent of Great Britain's physicians disapprove the national health act in its present form, according to a Reuters dispatch reported by the Chicago *Tribune* last month. A referendum conducted by the British Medical Association with 46,000 of Britain's 58,000 doctors voting resulted in an overwhelming defeat for the government plan.

Voting on another point, more than 25,000 British doctors declared they would refuse to accept assignments under the government's plan if it were effected as now proposed. Only 4000 doctors voted to accept service under the health scheme.

Prior to the referendum, Aneurin Bevan, health minister, stated publicly that he disapproved the British Medical Association's method of polling its membership and indicated that whatever the result of the voting, the government will not change its plan for putting the national health scheme into effect July 5. Following debate based on complaints registered by the medical profession, the House of Commons last month voted renewed support for the national health act.

Settle Controversy Over Blood Banks

NEW YORK.—Following cancellation of the Red Cross blood program in New York City last month because of conflict between the Red Cross and the New York County Medical Society over methods and objectives of the program, meetings between Red Cross and medical society representatives and city officials led to a compromise agreement under which the program will be extended gradually from municipal to voluntary hospitals.

The medical society's objections to the original program were based on fear that it would upset the existing blood bank system operated in private and voluntary hospitals by creating a demand for more blood than could be provided. Municipal health and hospital department officials, however, stated the Red Cross program would help to provide their needs for blood, which were not being met through previously established channels.

During the controversy which preceded development of the compromise solution, the medical society charged that the Red Cross failed to use approved modern technics in handling blood and the Red Cross charged that medical society opposition to the plan was motivated by "mercenary consideration." Both charges were denied.

Bill Seeks Funds for Nurses

NEW YORK.—A bill providing state subsidy for nursing education was approved here last month by the executive board of the Association of Registered Professional Nurses, C.I.O. The proposed legislation calls for $50 a month for students in the first two years of nurses' training and $75 a month for the third year. The purpose of the bill is to alleviate the critical nursing shortage that exists in New York State, Mrs. Sari D. Stone, president of the association, pointed out.

NEWS . . .

Nursing in Spotlight At Midwinter Meeting

(*Continued From Page* 130.)

patients' interests, Dr. Hullerman stated. He recommended that state hospital associations work with nurses' associations in the recruitment of students and other activities of common interest.

In another talk on nursing, Anson Lowitz of New York, vice president of the J. Walter Thompson Company, advertising agency which has assisted in the preparation of student nurse recruitment publicity, criticized nursing schools for their personnel practices. When his organization investigated several schools preparatory to working out the national publicity program, he said, they found that many schools were characterized by "discipline for discipline's sake." There must be a change in spirit at such schools, Mr. Lowitz said.

Burleigh Gardner, Chicago personnel consultant, said that executives are inclined to deceive themselves about how their employes really feel. When nurses join a union, Mr. Gardner warned, this is evidence that the organization is sick and requires careful study by the administrator.

Addressing another meeting of the group, Dr. Dwight Barnett of Detroit, chairman of the council on prepayment plans and hospital reimbursement, read a paper called "The Blue Cross Concept," summarizing relationship of Blue Cross plans and hospitals. "Without the sympathetic guidance and ultimate responsibility of hospitals," Dr. Barnett concluded, "the position of Blue Cross as one of the greatest voluntary public trusts cannot be sustained." The qualities which have made Blue Cross great, he added, are its nonprofit character, service benefits, broad public coverage, and methods and amounts of hospital payment. Dr. Barnett described a proposed nationwide study of hospital financing which is under consideration as a project for the council on prepayment plans.

Mrs. Nan Rowlands of Seattle asked that association officers consider extending the mid-year conference in the future to include state association presidents-elect, vice presidents, or whoever is scheduled to be an officer of the association during the coming year, in addition to present officers, so that greater continuity of state programs may be achieved.

NEWS . . .

Continue Hearings on Health Bills

WASHINGTON, D.C.—The Senate subcommittee which has been holding public hearings on S.545 to create a national health agency and S.1320 to provide national health insurance decided February 5 to hold further hearings in early March. Outstanding witnesses of the recent hearings have been Dr. Marjorie Shearon of the Shearon Medical Legislative Service; and Dr. I. S. Falk, director of the Bureau of Research and Statistics of Social Security Administration.

The subcommittee has almost completed hearings on these two bills—hearings which ran through a good part of 1947. It must now decide, according to Dr. Shearon in her testimony, (1) whether there is a national health problem calling for federal intervention, (2) whether any federal legislation—one of these or some other bill—is called for at this time, and (3) assuming that some legislative action is desirable, which type of legislation is best suited to American needs.

Dr. Shearon has testified at length on the philosophy and implications of the two bills under consideration. She has been active in opposing S.1320, the Murray-Wagner bill, an active adherent of S.545 whose authors are Senators Donnell and Taft. Dr. Falk is an advocate of compulsory health insurance.

Dietitians' Group Given $1000 Award

CHICAGO.—An award for outstanding accomplishment, including a grant of $1000, was presented in February to the American Dietetic Association by the Nutrition Foundation, New York City, it was announced by Gladys Hall, executive secretary of the association.

Dr. Charles Glen King, scientific director of the Nutrition Foundation, said the award was authorized by that group's board of trustees for the purpose of giving dietitians greater recognition for their professional service to the public.

The testimonial accompanying the award read in part as follows: "This award for outstanding accomplishment is presented to the American Dietetic Association in recognition of the leadership, inspiration and diligence of its members in applying and in developing the science of nutrition in hospitals, government service, food clinics, public health agencies, school lunchrooms, colleges and universities, and in industrial organizations, for the advancement of human health."

Reach 117 Per Cent of Goal

BOISE, IDAHO.—The United Hospital Building Fund campaign here passed $700,000 last month, or 117 per cent of the $600,000 sought to expand Boise's hospital facilities, the *Idaho Daily Statesman* reported. Purpose of the campaign was to raise funds for construction of 100-bed additions to both the St. Alphonsus and St. Luke's hospitals in this city. "The people of Boise have shown how solidly they are behind our two hospitals and how deeply they appreciate really worthwhile organizations," C. C. Anderson, chairman of the fund drive, declared. It was expected that still more money would be raised before the campaign closed, the newspaper reported.

NEWS . . .

Mass Recruitment of Nurses Unsatisfactory

CHICAGO.—"Mass recruitment" of student nurses is not working satisfactorily and will not solve the problem of an inadequate supply of nurses, Ella Best, executive secretary of the American Nurses Association, declared at a conference of nurse registry executives here last month. Miss Best said that the effort to recruit large numbers of students was "a tragic waste of time and money," because four out of every ten students recruited drop out before their training is completed.

Miss Best said most professional nurses favor the so-called "negative" recruiting method in which the prospective student is carefully selected and given a thorough factual grounding on the conditions she may be expected to find in nursing schools and in the profession.

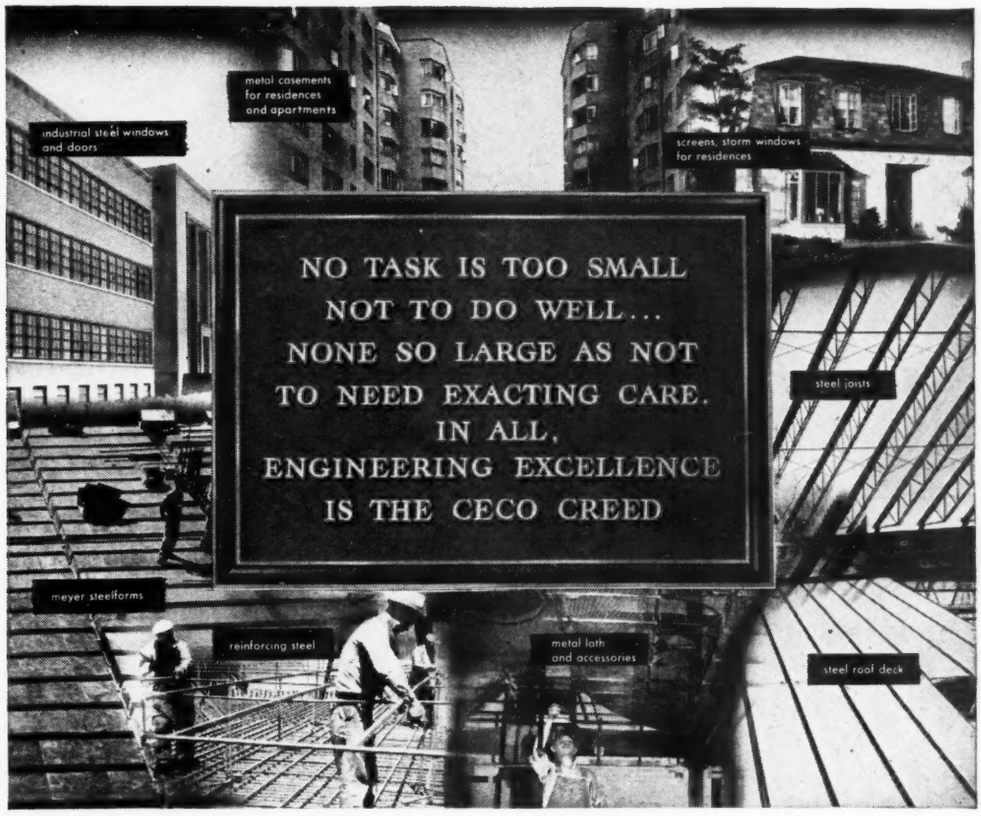
Other speakers at the conference suggested group nursing plans under which several hospital patients share the services of one private duty nurse, and hourly nursing service providing private duty nurses who visit several patients at their homes during the day.

No Overtime, Nurses Say

LOS · ANGELES.—Surgical nurses in four Los Angeles hospitals have declared they would not accept calls for overtime duty, according to an International News Service report here last month. The nurses were said to have demanded time and a half for periods during which they were on call after going off duty. I.N.S. also reported that a spokesman for the California State Nurses' Association said hospitals were notified in November that the surgical nurses' ultimatum would take effect in January unless nurses were given a contract covering this and other conditions of work.

Dr. Hildreth Gets Post

WASHINGTON, D.C.—Dr. Harold M. Hildreth was named chief of clinical psychology for the Veterans Administration January 1. He succeeds Dr. J. G. Miller who has resigned to accept the chair of the department of psychology at the University of Chicago. Dr. Hildreth has been serving as chief of clinical psychology in V.A.'s San Francisco branch office.



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Thirty-six years ago an attitude, an ideal, started Ceco Steel Products Corporation. Today, that attitude, that ideal, is summed up in a Creed, which best describes the way Ceco and all its people have worked to build the company. No lofty phrases make up this Creed, but simple direct language.

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NEWS . . .

Campaign for Funds to Aid Cincinnati Nurse Training Plan

CINCINNATI.—Opening a campaign to raise $500,000 for the Cincinnati committee on better nursing, Dr. A. Ashley Weech of the Children's Hospital Research Foundation here declared in January that practical nurses have proved their value in assisting graduate nurses at Children's Hospital

The committee's program includes establishment of a training course for practical nurses and an advanced course of nursing education for graduates.

"We do not now have nor are we likely to have for some time to come enough highly trained nurses to take care of the sick," Dr. Weech stated. "Our interest in the training of nurses comes of the practical realization that we must get the number of nurses we need. I believe there is a big field for the practical nurse in pediatric nursing. Children take more nursing hours than does the adult patient because they cannot do things for themselves.

"The practical nurse would set the graduate nurse free to study more. The profession of nursing as a whole would benefit and that means that the patient would benefit, for the goal of nursing is the bedside care of the patient."

Damage Suit Charges Use of Defective Plasma

LOS ANGELES.—A suit was filed in superior court here recently charging that defective blood plasma was administered to a patient at the Los Angeles County General Hospital a year ago. Brought by the patient's widow and children, the suit claimed that the defective plasma caused the patient's death.

A check of hospital records indicated that nothing was wrong with the plasma used on August A. Montez, the patient who died Feb. 2, 1947, an official of the hospital stated. "As far as has been ascertained," a hospital representative stated, "he died from an infection—infectious hepatitis. He had gone home after receiving the plasma injection, then came back to the hospital. No similar difficulties have been had with other patients undergoing similar treatment, so it must be assumed that Mr. Montez contracted the infection while at home."

Influenza Cases Reported to U.S.P.H.S.

WASHINGTON, D.C.—Telegraphic reports to the U.S. Public Health Service last month indicated that the number of influenza cases reported to local and state health departments was increasing sharply all over the country.

Pronounced increases were noted especially in South Carolina, Virginia, Arkansas, Texas and California, it was reported.

Public Health Service officials were said to be "not particularly concerned" over the statistical increase, it was explained, because "reporting was haphazard in most places and comparatively few of the diagnoses of influenza had laboratory confirmation." Moreover, the national influenza total was still far below the incidence for a year ago, the report stated.

NEWS . . .

Resurrection Sisters Seek Funds for Chicago Hospital

CHICAGO.—A hospital of 150 beds to serve an estimated 175,000 population on Chicago's north and northwest sides is being planned by the Sisters of Resurrection for early construction. The sponsors' committee representing the communities which will be served by the proposed hospital is presently engaged in a fund raising program, according to Joseph Guenther, chairman of the sponsors' group.

Population of the area now lacking hospital facilities has increased from 50,000 in 1920 to 168,000 in 1940, Mr. Guenther said, and city and suburban planning authorities estimate that the area will include 284,000 people by 1960.

"Despite this vast population surge," Mr. Guenther pointed out, "not a single hospital bed has been installed to serve the health needs of the area. Instead, the sick must go to distant hospitals for aid."

Shortley Addresses Orthopedic Surgeons

CHICAGO.—More than a million and a half disabled American civilians could be restored to remunerative employment through rehabilitation services now available, Michael J. Shortley, director of the U.S. Office of Vocational Rehabilitation, told the American Academy of Orthopedic Surgeons.

The two greatest problems faced in clearing up the accumulated backlog of the disabled are, according to Mr. Shortley, "the finding and encouragement of medical and hospital resources, and the early and purposeful union of medical with other vocational rehabilitation services to produce a balanced rehabilitation of the whole man."

Urging physicians and hospitals to bring not only medical and hospital services but many more strictly vocational services to the actual bedside as soon as possible after the onset of disablement, Mr. Shortley also urged academy members to bring their war and civilian rehabilitation experiences directly to state rehabilitation agencies in the form of professional advice and guidance.

Convalescent Home Abandoned as Unsafe

IOWA CITY, IOWA.—The convalescent home unit of the State University of Iowa Hospitals was evacuated last month, Gerhard Hartman, superintendent, has reported. "The building was judged unsafe for such use by the State Fire Marshal after his office inspected it at our request," Mr. Hartman stated. The two story, frame building has accommodated about twenty to twenty-five children at a time during its eleven-year history as a convalescent home, it was explained.

Occupants of the home were moved to the children's hospital at the university, Mr. Hartman said. "We must abandon the building, but we cannot abandon the care of the convalescent," he stated. "Despite the fact that this will complicate an already overcrowded situation in Children's Hospital, we believe the care of the convalescents to be an essential and necessary service of the University Hospitals to the indigent sick of the state," he said.

NEWS . . .

Survey Completed of High Pressure Steam Boilers in V.A. Hospitals

WASHINGTON, D.C.—The Veterans Administration was prepared by January 15 to begin study of a survey of all high pressure steam boilers maintained and operated in V.A. hospitals, homes, supply depots and offices. Contracting for annual boiler inspection services on a nationwide basis was the purpose of the survey.

The survey covered such data as the location and station number of the boiler; name of its manufacturer; type (water tube, fire tube); rating information taken from the manufacturer's data or as stamped on the boiler; lowest safety valve setting in pounds per square inch; type of fuel burned, and type of firing equipment (stoker, hand-fired or oil burner).

The survey determined also the number of boilers under construction and the approximate date on which they will be available for use, as well as the number of boilers scheduled to be retired from service or replaced by new equipment.

V.A. Reports Increase in Women Patients

WASHINGTON, D.C.—An increase of 905 women veteran patients in its hospitals during the last fifteen months has been reported by the Veterans Administration.

The 2035 women veterans confined to hospitals last October included 246 with tuberculosis, 502 with psychoses; 135 with other neuropsychiatric disorders, and 1152 general medical and surgical patients. More than half of them were veterans of World War II.

For Mental Health Research

WASHINGTON, D.C.—Award of six more grants for research in mental health under the National Mental Health Act has been announced. Twenty-five research grants have already been announced. The following institutions received grants: University of California, Berkeley; College of Physicians and Surgeons, Columbia University; Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Me.; Mu Iota Sigma fraternity, Illinois School for the Deaf, Jacksonville, Ill.; Wayne University School of Public Affairs and Social Work, Detroit; Wesleyan University, Middletown, Conn.

Cancer Is Theme of Pharmacy Week

WASHINGTON, D.C.—Arrangements have been made with the American Cancer Society to make public education on cancer control a theme of the observance of National Pharmacy Week, April 18 to 24. The continuing urgency of the cancer control problem promises to make this further endeavor in the health education field of great importance to the public as well as to the profession, the National Pharmacy Week Committee has pointed out.

To Amend Food, Drug Act

WASHINGTON, D.C.—The House passed, on January 13, a bill amending the Food, Drug and Cosmetic Act relative to misbranding of articles of food and drugs, and regarding their seizure and condemnation.

ABOUT PEOPLE

(*Continued From Page* 94.)

Hospital, Duluth, Minn., died at the hospital in January.

Charles K. Le Vine has been promoted from acting superintendent to superintendent of the Jewish Consumptives' Relief Society Hospital at Spivak, Colo. Mr. Le Vine is a member of the American Hospital Association and the Colorado Hospital Association. He is vice chairman of the Denver Area Sanatorium Council.

Dr. Robin C. Buerki, dean of the graduate school of medicine and director of the University of Pennsylvania Hospitals, has been appointed to the medical advisory board of the United Mine Workers Welfare and Retirement Fund, **Dr. R. R. Sayers,** chairman of the board, has announced.

Gerhard A. Krembs has taken over the position of superintendent of Door County Memorial Hospital, Sturgeon Bay, Wis., left vacant by the resignation of **Franklin D. Carr.**

Mrs. Mary Evans, R.N., has been appointed superintendent of Beloit Municipal Hospital, Beloit, Wis. She replaces **Margaret W. Johnston** who announced her retirement recently.

Department Heads

Dr. J. Murray Steele, associate professor of medicine at New York University College of Medicine, has been appointed director of the third N.Y.U. research service at Goldwater Memorial Hospital, New York City.

Dr. Isadore Rothstein has been appointed assistant director of laboratories and attending hematologist at Bronx Hospital, New York City. Announcement was made also of the appointments of **Dr. Andre C. Kibrick** in charge of the department of chemistry, and **Dr. Alfred J. Weil** in charge of the department of bacteriology.

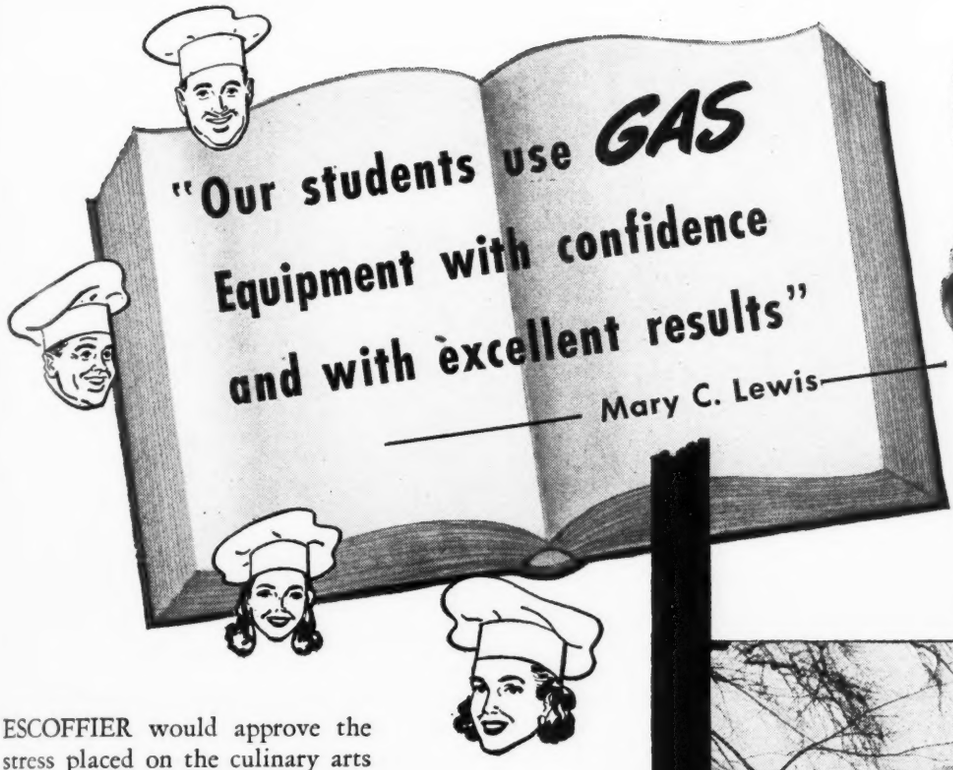
Mrs. Hertha McCully has resigned as executive housekeeper of Jewish Hospital in Philadelphia to accept a similar position at the new George Washington University Hospital, Washington, D.C., which is scheduled to open on March 10.

Mrs. Florence W. Rehfeld on February 15 became director of nurses at Rockford Memorial Hospital, Rockford, Ill., succeeding **Prudence Appelman,** who resigned. Mrs. Rehfeld received B.S. and R.N. degrees from the University of Iowa in 1928. She holds a master's degree in education from Marquette University, Milwaukee, and has had additional graduate work at the University of Wisconsin.

Jules Freedman has been named director of the physical therapy department of Beth Abraham Home for Incurables, Bronx, N.Y. He was formerly associated with Hastings State Hospital, Hastings, Neb., and with St. Luke's and Children's Medical Center, Philadelphia.

Trustees

Jay L. Hench was elected president of Wesley Memorial Hospital, Chicago, at a recent meeting of the board of trustees. Mr. Hench has been treasurer and chairman of the hospital's budget committee since 1941, when the hospital moved to its present site at 250 East Superior St. He is president of Mid-West Forging and Manufacturing Company of Chicago and Chicago Heights. Mr. Hench succeeds **John Holmes,** president of Swift & Co., who has served as president of the hospital for the past six years.



Mrs. Mary Catherine Lewis, President, Lewis Hotel Training School, only school of its kind in the world.

ESCOFFIER would approve the stress placed on the culinary arts at Lewis Hotel Training School, Washington, D.C. You find the results of this thorough teaching wherever Lewis-trained hotel executives preside.

There, too, you'll probably find GAS and modern Gas Kitchen Equipment because Lewis training places emphasis on the tradition that "where food is finest it's cooked with GAS."

That's why President Mary Catherine Lewis takes great personal interest in the Lewis training-kitchens which are equipped with the most modern GAS cooking and food-service tools:

Hot Top Range	**Bake Oven**	**Steam Table**
Open Top Range	**Coffee Urns**	**Plate Warmer**
Deep Fat Fryer	**Broiler**	**Dishwasher**

The successful experience of Lewis Hotel Training School in the use of GAS for culinary training emphasizes the simplicity, flexibility, speed, and controllability of this superior fuel.

Regardless of the type or size of your food-service facilities you'll find modern Gas Kitchen Equipment designed to aid you in obtaining superior cooking results. Your local Gas Company Representative will assist you.

Headquarters building, Lewis Hotel Training School, Washington, D. C., founded by Clifford and Mary Lewis in 1916.

Students are trained in quantity cookery techniques in the Lewis school's Gas-equipped kitchen.

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Miscellaneous

W. G. Follmer has been appointed full time accounting consultant for the Hospital Association of Pennsylvania. Mr. Follmer was formerly staff accountant for the Rochester Hospital Council, Rochester, N.Y.

E. Burns Geiger has been appointed chief of the pharmacy division of the Veterans Administration Department of Medicine and Surgery. Previously, Mr. Geiger was assistant to **W. Paul Briggs,** former chief of the division.

Dr. Warren H. Cole, head of the department of surgery at the University of Illinois, has been appointed senior scientist attaché to the United States Mission to Britain for Science and Technology.

Florence A. McQuillen, R.N., has been named to succeed **Anne M. Campbell** as executive director of the American Association of Nurse Anesthetists.

Dr. Kendall Emerson, whose resignation as managing director of the National Tuberculosis Association was reported recently, has been elected president of the New York Tuberculosis and Health Association.

Hugo V. Hullerman, M.D., assistant director of the American Hospital Association and secretary of the council on professional practice, will leave May 1 to become assistant director of the Rhode Island Hospital, Providence, R. I. A graduate of the University of Minnesota School of Medicine, Dr. Hullerman was in private practice for several years before entering the public health field as an epidemiologist for the Illinois State Health Department in 1939. He holds the master's degree in public health administration from the University of Michigan. Before going to the hospital association in 1944, Dr. Hullerman became chief of the Illinois division of maternal and child hygiene.

William G. Simmons, secretary of the American Hospital Association's council on association relations for the last two years, leaves April 1 to become vice president in charge of hospital relations of Hospital Consultants, Inc., and a member of the staff of Ross Garrett & Associates, St. Louis. Mr. Simmons joined the headquarters staff of the association following his discharge from the army, which he served as an officer in the medical administrative corps overseas. Before going into the army he was with the Blue Cross Plan for Hospital Care, Chicago.

Rev. Donald A. McGowan, former diocesan director of hospitals, Boston, is now assistant director of the department of social action of the National Catholic Welfare Conference in Washington, D.C. Reverend McGowan's activities in the hospital field include being president of the New England Hospital Assembly, vice president, Massachusetts Hospital Association, member of the administrative board, Catholic Hospital Association, and member of the Superintendents' Club of New England. He is also vice president of the American Hospital Association.

Arnold F. Emch has been elected to partnership in the firm of Booz, Allen and Hamilton, management consultants with offices in New York, Chicago and Los Angeles. Mr. Emch was formerly head of the Chicago Hospital Council and later, associ-

ate director of the American Hospital Association.

Mrs. Edna K. Huffman, R.R.L., former director of the school for medical records librarians at Wesley Memorial Hospital, Chicago, has accepted appointment as field representative for the American Association of Medical Record Librarians. A past president of the association, Mrs. Huffman is the author of the textbook "Manual for Medical Records Librarians."

A. Philip Browne has been appointed purchasing agent for Hartford Hospital, Hartford, Conn., Dr. Wilmar M. Allen has announced. Mr. Browne was formerly in charge of purchasing at the Institute of Living, a private mental hospital in Hartford.

Deaths

Dr. Thomas Howell, former superintendent of the New York Hospital, died January 24 at the hospital. Dr. Howell was born in Winona, Minn., in 1868 and was graduated from Bowdoin College and Dartmouth Medical School in 1895. He was appointed superintendent of the New York Hospital in 1909, serving in that capacity until 1935 when he became director of Overlook Hospital, Summit, N. J. In 1942, Dr. Howell rejoined the staff of the New York Hospital as head of the outpatient department, which position he held until his death.

Josiah Kirby Lilly, chairman of the board of directors of Eli Lilly and Company, Indianapolis, died February 8 at the age of 86. Mr. Lilly was graduated from the Philadelphia College of Pharmacy and Science in 1882. He became associated with the company founded by his father in 1876, and was elected its president on the death of Col. Eli Lilly in 1898. He retired from active service with the company on Jan. 1, 1945.

Kenneth H. Gordon, assistant director of Woman's Hospital, New York, died September 9. Before removing to New York, Mr. Gordon was administrator of Greene County Memorial Hospital, Waynesburg, Pa.

Dr. Max Seide, medical superintendent, Cumberland Hospital, Brooklyn, N.Y. died suddenly of a heart attack. Dr. Seide was formerly superintendent of Coney Island Hospital, Brooklyn.

TB Sanitarium Needs "Official Observer"

CHICAGO.—Establishment of an "official observer" at the Municipal Tuberculosis Sanitarium here was sought by the city council in connection with its consideration of the sanitarium budget for the coming year. The sanitarium is being reorganized under the direction of a new board of trustees consisting of Francis R. Lyons, president; Dr. Herman N. Bundesen, vice president, and Dr. Ernest E. Irons.

Dr. Arthur W. Newitt is tuberculosis control officer at the sanitarium.

Pointing out that neither the city council nor the mayor had the right to appoint a council member to the sanitarium board, the corporation counsel added that the council did have power to appoint an alderman as official observer.

Osteopathic Hospital Planned

NEW YORK.—A 100 bed osteopathic hospital is planned for New York City, Dr. Omar C. Latimer, president of the Osteopathic Society of New York City, announced last month. Permission to construct the hospital has been obtained from the state, it was explained. A campaign for $1,500,000 to purchase the site and erect the building will be undertaken shortly, the announcement said. The new hospital will be known as the Osteopathic Hospital and Clinic of New York.

What's New for Hospitals

MARCH 1948 SUPPLEMENT TO THE MODERN HOSPITAL

Safety Step for Hospital Beds

The new Hill-Rom Safety Step, for the convenience and safety of patients in getting in and out of hospital beds, is

attached to the hospital bed by a supporting frame which extends from one side of the bed to the other. This distributes the strain on both sides of the bed rather than on just one angle iron and permits the Safety Step to be easily attached to either side of the bed.

The Safety Step provides a permanent, solid, stationary step for getting in and out of bed, thus preventing groping and accidents. When stepping from the floor the patient steps directly onto the bed, in using the Safety Step, thus eliminating the possibility of slipping or falling. The step is closed up against the bed when not in use and easily opened by the patient when needed.

In addition to its use for getting in and out of bed, the Safety Step is ideal for the use of surgical and maternity patients who must sit up on the edge of the bed a certain period each day. The step provides a firm footing which adds to the patient's feeling of security and strength and it is ready for immediate use by the patient without the necessity for calling a nurse. The step platform is covered with aluminum and the wood parts are finished to match the bed ends. The step has been strength tested to hold safely at least 400 pounds. **The Hill-Rom Company, Dept. MH, Batesville, Ind. (Key No. 4005)**

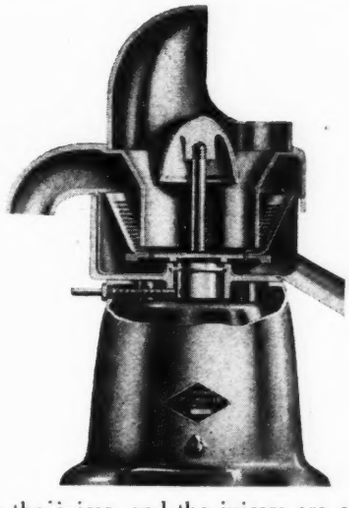
Surgical Instrument Cleanser

Coagusol is a new brushless, no scrubbing, surgical instrument cleanser. Its swift, thorough detergent action is designed to free the most soiled surgical instruments of all particles of dried blood, fat tissue and other matter, even in the finest serrations, close locks and grooves. The solution cleans the instruments chemically, preparing them for sterilization in a matter of minutes, without brushing or scrubbing.

Two chemical agents with quick cleansing action, while at the same time harmless to instruments and to hands, give Coagusol its effectiveness. It can be used on rubber, glass and metal surgical equipment, syringes and needles, intravenous equipment, masks, flasks, tubes and the like. **Hospital Liquids Inc., Dept. MH, 2900 S. Michigan Ave., Chicago 16. (Key No. 4006)**

Citrus and Vegetable Juicers

Newly developed juicers for citrus fruits and all deciduous fruits and vegetables have been announced by California Juice-Master Company. All juices in the fruit or vegetable are strained from the pulp into a bowl and the pulp is forced out through an expulsion spout. These operations are entirely automatic, including feeding the fruit or vegetable



into the juicer, and the juicers are continuous in operation, it being unnecessary to stop to remove pulp or seeds during the process.

The juicers are made of highly polished, food-processing machinery aluminum alloy with all parts, which come in contact with the juices, of stainless steel. A stainless steel rotating basket strains the juices into a stainless steel bowl in a process that gets all the valuable elements out of fruits or vegetables. All varieties of fruits and vegetables can be turned into juice by these automatic extractors. **California Juice-Master Co., Dept. MH, 690 Market St., San Francisco 4, Calif. (Key No. 4007)**

Cracked Ice Cart

A new all stainless steel cracked ice bulk distributing cart provides both

transportation and storage of cracked ice The cart is all stainless steel, inside and out, has three inches of Zero type insulation and hand operated drain. The two lids are designed so that there is minimum temperature loss when open.

The Model XV cart is 30 inches long, 21 inches wide and 42 inches high. It has two large 12 inch wheels with small matching wheel in rear. The propeller handles have rubber grips and the machine is designed to fit under the discharge of an ice ribbon machine, ice cube maker or ice cracker for filling. It is easily propelled to point of usage for either unloading into permanent storage cabinets or using for storage itself. **Gennett and Sons, Inc., Dept. MH, Richmond, Ind. (Key No. 4008)**

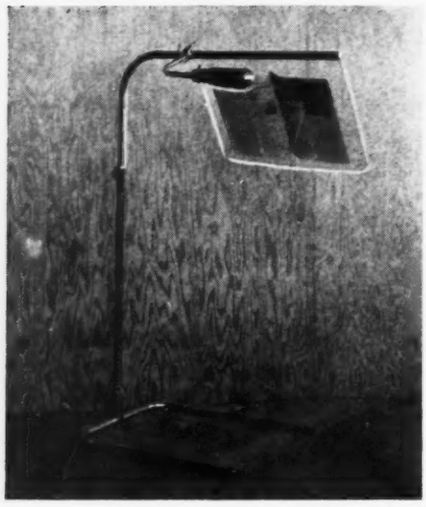
Insecticide Concentrate

A new group of insecticide concentrates, known as the Pyrenones, has been developed by U. S. Industrial Chemicals, Inc. Of particular importance is the fact that while these chemicals are lethal to a wide range of insect life, they are harmless to warm-blooded animals and can thus be used safely in food storage and preparation rooms and in many other areas in the hospital where insects may be a problem. The product is not only effective for immediate results, but has long residual effectiveness.

The basic chemical concentrate is provided by the company to individual insecticide manufacturers who will produce, under their own trade names, the types of insecticides required for various uses. **U. S. Industrial Chemicals, Inc., Dept. MH, 60 E. 42nd St., New York 17. (Key No. 4009)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 264

Lucite Overbed Table



A new overbed table has been designed with the special needs of patients who must lie flat in bed in mind. Made of clear lucite, the table has an adjustable reading lamp and is designed so that a book or magazine can be placed upside down on the lucite table, the light swung underneath to illuminate the reading matter, and the patient can read through the lucite without having to have his head raised. Used in this manner, the lucite table area is so adjusted that the reading matter is comfortably slanted for reading in a prone position. The table can also be used in the regular manner as an overbed table.

The arm and base are of tubular steel and can be readily adjusted as to height and position. The lucite table section with adjustable lamp can be used, by patients who can sit up in bed, for reading, writing and other purposes. **Everest & Jennings, Dept. MH, 7748 Santa Monica Blvd., Los Angeles 46, Calif. (Key No. 4010)**

"Alumiline" Furniture

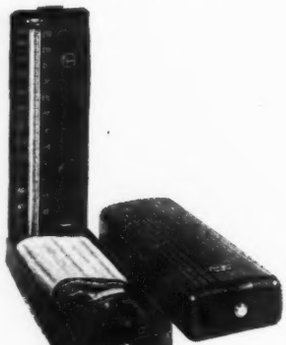
A new line of furniture, known as "Alumiline," has been announced by A. S. Aloe Company. Frames are constructed of square aluminum tubing anodized for corrosion resistance. Working surfaces, shelves, drawers, basins and pails are constructed of stainless steel. The combination of metals results in durable equipment, lighter in weight and lower in cost. Each piece has a new, flowing design which combines attractive appearance with utility.

The new line includes nursery furniture, equipment for the surgery, from kick buckets and irrigator stands to instrument tables and anesthetist's stands, portable dressing and supply carriages and nurses' and chart desks. The framework of the line is smoothly welded into continuous units without joints, seams or screws, thus giving permanent structural rigidity to each unit. The frames as well as the stainless steel tops, drawers and compartments are welded and smoothly finished throughout for ease in cleaning and in maintaining an aseptic state. Casters and wheels are ball-bearing. The permanent finish also facilitates cleaning while providing an attractive appearance. **A. S. Aloe Company, Dept. MH, 1831 Olive St., St. Louis 3, Mo. (Key No. 4011)**

Audiometer for Hearing Loss Tests

The new Deluxe Model 50-E Audiometer provides a new speech test through use of a meter-calibrated speech circuit. The new dynamic microphone and meter control the level on speech tests so that actual speech hearing loss measurements are possible. A simplified hearing loss dial provides measurement of hearing loss for both bone and air conduction. Hospitals conducting hearing tests will find many advantages in the new model. **The Audio Development Co., Dept. MH, 2833 13th Ave. S., Minneapolis 7, Minn. (Key No. 4012)**

Tycos Mercurial



The new Tycos Mercurial has been designed to withstand the hard daily usage which the instrument would receive in a hospital. The die-cast aluminum case has heavier walls and the glass tube is completely recessed behind the reenforced, easy-to-read scale to minimize the possibility of breakage. The Hook-Cuff with sixteen different adjustments for instant fit on any size arm is standard equipment with the instrument and fits easily into the case, or the unit is available at a lower price with the bandage cuff.

The new instrument has all of the features of other Tycos instruments and the Tycos Guarantee covers not only replacement of the glass tube if broken, but also of the case and all parts, except inflation system, for a period of ten years. The unit is guaranteed to remain accurate indefinitely if correctly used. **Taylor Instrument Companies, Dept. MH, Rochester 1, N. Y. (Key No. 4013)**

Amsco Brush Dispenser

The new Amsco Brush Dispenser is designed to hold 12 sterile hand brushes which are automatically dispensed, one at a time, by a simple pull on the ejector handle at the bottom of the cabinet.

Made of stainless steel, each dispenser has a wood board for wall mounting. Three set screws hold the dispenser firmly in place and it is easily removed for autoclaving by simply raising it from the screws. A fitted sliding panel in the front of the dispenser can be removed for filling and for sterilizing. The unit is small and compact, attractively designed and makes it possible to have a ready supply of sterile brushes. **American Medical Specialties Co., Inc., Dept. MH, 12 E. 12th St., New York 3. (Key No. 4014)**

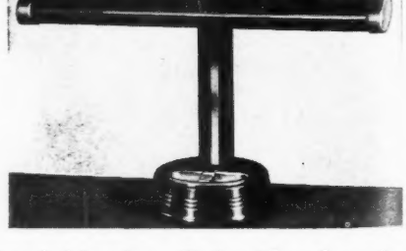
Electric Floor Polisher

The new Clarke electric floor polisher is especially designed for maintenance of small areas. It is suitable for laboratories, kitchens, offices and other smaller areas where a large machine is not practical.

The high speed rotating brush action of the machine burnishes wax deep into the floor covering, leaving no surface accumulations. This gives a high luster to the waxed flooring and longer wear for each application. The unit weighs only 11½ pounds, is compactly designed for economy of storage space and has a die-cast aluminum housing. It operates on 110 volt AC or DC and is constructed for dependable service. **Clarke Sanding Machine Co., Dept. MH, Muskegon, Mich. (Key No. 4015)**

Fluorescent Desk Lamp

The new No. 20000 fluorescent desk lamp is streamlined in design and finished in statuary bronze with chrome finish. A removable receptacle in the base can be used as a utility tray for pen and pencil, for clips, or as an ash tray. The lamp is 12¼ inches high. The shade is 19 inches long. The lamp has a turn-button switch in the base and a 10 foot rubber-covered cord with unbreakable plug. **Faries Manufacturing Company, Dept. MH, Decatur, Ill. (Key No. 4016)**



Address manufacturers for further information and prices—or use Readers' Service blank on page 264

Inside Metal Storm Sash

The new Fenestra Inside Metal Storm Sash is designed to be a part of a complete window unit—steel casement, screen and inside metal storm window. The new storm window is available, if desired, with a tilt-in vent at the bottom to provide draftless ventilation. It is quickly and easily installed from inside the room and a rubber gasket, attached to the frame prevents metal to metal contact and acts as a quick seal for the whole opening.

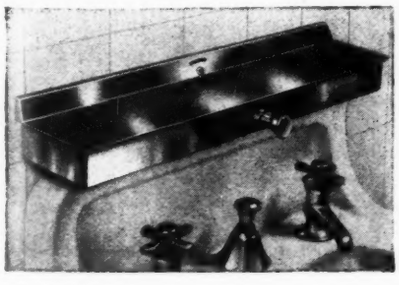
Heat loss is reduced by installation of the storm window which also keeps the windows clear even in coldest weather. The new window is form steel, bonderized, with the paint baked on at the factory. **Detroit Steel Products Co., Dept. MH, 2250 E. Grand Blvd., Detroit 11, Mich. (Key No. 4017)**

DC Pan Glaze

Hospitals doing their own baking, whether of all items or only specialties, will be interested in DC Pan Glaze. This silicone product, when sprayed and baked onto baking pans, eliminates the necessity for larding or greasing the pans before using. One application of Pan Glaze is reported to last for approximately 200 bakings, thus effecting a real saving in fats which would otherwise be used in the pans. The improved product is not affected by high relative humidity in the proof box, pans are more easily cleaned and the bread baked in Pan Glaze coated pans is more uniform and more evenly browned. **Dow Corning Corp., Dept. MH, Midland, Mich. (Key No. 4018)**

Lathurshelf Soap Dispenser

The Lathurshelf provides a combination shelf and soap dispenser. Made of 18-8 polished stainless steel to do away with rusting or tarnishing, the unit is available in one or two basin sizes and contains a large supply of liquid soap. Creamy lather is dispensed by a push-button so designed as to prevent leakage or dripping and the snap lock on the cover can be opened only with the key



supplied to those in charge of maintenance.

The unit is attractive in appearance while serving its double purpose as shelf and dispenser. It has a capacity of a half gallon of liquid soap, the level of which is indicated by a visible gauge. The shelf is 20 inches long, 4½ inches wide and 2 inches high and is available with either one or two lather valves. **American Dispenser Company, Inc., 215 Fourth Ave., New York 3. (Key No. 4019)**

Walking Aid

Patients learning to walk again after a long illness, paralysis, amputation or other handicap will be helped by the Walking Aid. Developed during the war and tried out in Veterans Administration hospitals, this unit is now available to all institutions.

The Walking Aid is constructed of light weight hardwood and steel with rubber tipped legs to prevent slipping. It is sturdy, lightweight and adjustable and can be collapsed for storage or transportation. The user stands upright,

pushing or moving the Walking Aid in front of him. Its four sturdy legs give the user full support and confidence. **The Anchor Mfg. Co., Dept. MH, Piqua, Ohio. (Key No. 4020)**

Vitallium Contact Splint

The Eggers Vitallium contact splint was designed by Dr. G. W. N. Eggers of the University of Texas School of Medicine to promote more assured and rapid healing of fractures. Made in the form of slotted plates, the Eggers splints are fastened loosely to the bone with Vitallium screws, thus permitting sliding end-to-end motion while opposing distraction of the fracture. **Austenal Laboratories, Inc., Dept. MH, 224 E. 39th St., New York 16. (Key No. 4021)**

Dresser—Desk—Vanity Unit

The new Simmons combination vanity, desk and dresser unit will save space in furnishing nurses' homes, personnel dormitories and patients' rooms, especially in private rooms requiring desks and in rooms for chronic and convalescent patients. It combines unusually attractive design and finish with practical versatility. The one unit serves as a dresser with three drawers, all with silent, easy action wood guides, as a dressing table with mirror and as a knee-hole desk with drawer for writing materials or cosmetics.

The Van-D-Dresser is of rigid construction, insulated for quiet operation of drawers. Spring clip, rubber cushioned stops prevent drawers opening to the point of falling and the top drawers have center partitions. It is a utility unit which provides, at the same time, an unusually attractive, room-saving piece of furniture. Using the Van-D-Dresser a small room with limited wall space can still provide the occupant with all required facilities. The case is available in a wide selection of lasting finishes and is 30½ inches high with top 21 by 59½ inches. **Simmons Company, Dept. MH, 222 North Bank Drive, Chicago 54. (Key No. 4022)**

Fluid-Drive Elevator

A less powerful motor, fewer switches to service and smaller elevator machinery rooms are some of the advantages stated for the new "Gyrol" fluid drive introduced by the Warsaw Elevator Company. Only a single switch is required for upward travel and another for downward travel with the new fluid drive, thus simplifying the electrical control system. Hairline levelling and smooth starting and stopping are also mentioned as normal operation with this new "single speed" equipment. **Warsaw Elevator Co., Dept. MH, Warsaw, N. Y. (Key No. 4023)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 264

Holt Whirlwind Vacuum Cleaner

The new Holt Whirlwind Industrial Vacuum, Model VA 20, for both wet and dry pickup, is designed to meet every

maintenance need. As a dry vacuum it handles all dust and general clean-up problems and is efficient for wet pickup in scrubbing and rug shampoo operations. It has 18 attachments and accessories to cover all needs.

This heavy-duty machine is unusually quiet in operation and has a two-stage fan mounted below the motor to eliminate much of the sound. The unit has three solid rubber casters which give it firm, three-point support on rough or uneven surfaces and make it easily portable. It is quickly adaptable to either suction or blowing and has a 15 gallon tank capacity. It is built of heavy gauge metal, finished in baked, crackle finish with rust and corrosion proof rubber enamel as inside finish. It has a powerful 115 volt grease-sealed motor. **Holt Mfg. Co., Dept. MH, 20th & Grove Sts., Oakland 12, Cal. (Key No. 4024)**

Drinking Water Cooler

The new Temprite Cooler is a self-contained unit with all stainless steel top and drain assembly and automatic water-flow regulator. The bubbler is so designed that the user's lips cannot come into direct contact with the water nozzle, thus giving maximum sanitary protection. The new unit has a 10 gallon capacity and a glass filler attachment is available as optional equipment. **Temprite Products Corp., Dept. MH, 47 Piquette Ave., Detroit 2, Mich. (Key No. 4025)**

Hidalift Sash Balance

A completely balanced window sash which permits finger-touch opening of windows is the description given of the new Hidalift Sash Balance. This device, which is installed in the sash out of sight, has a lifting quality which makes it easy to open heavy windows while at the same time it eliminates drafts since it is weathertight. Tension is easily adjusted without removing the sash or screws and the Hidalift is designed for long, trouble-free use. It can be installed in new windows and for modernizing old ones. **The Turner & Seymour Mfg. Co., Dept. MH, Torrington, Conn. (Key No. 4026)**

Hand Linen Marker

The new Applegate automatic linen marker is a hand stamper sturdily constructed of chrome metal. It can be held securely in place with one hand while the other hand operates the plunger. Designed for use where the larger hand and foot operated machines are not needed, the hand stamper has the same dies used on the larger machines. They are hand tooled from solid metal for long wear and efficient marking. The new stamper should prove useful in marking special lots of linen that are used for special purposes and for similar mark-

ing requirements. **Applegate Chemical Co., Dept. MH, 5630 Harper Ave., Chicago 37. (Key No. 4027)**

Turco Nu-Vex

Turco Nu-Vex is a new liquid penetrating seal for protecting all types of wood floors from dirt, grime and wear. It penetrates deep into the wood to seal pores and cells and to form an oil and water resistant surface. It is clear, odorless and transparent and is designed to restore the original appearance of old floors without darkening or staining the wood. It provides a foundation for a permanent glossy sheen when floors are waxed and polished, will not chip, crack or peel, and is designed for floors subjected to heavy traffic. Nu-Vex is easily applied. **Turco Products, Inc., Dept. MH, 6135 S. Central Ave., Los Angeles 1, Calif. (Key No. 4028)**

Weldwood Fireproof Door

Incombustible Kaylo insulation is used as the solid core of the new Weldwood fireproof door. Standard hardwood faces and cross banding are laminated to the core with Tego Film waterproof glue and the door is completely bonded on all four edges with solid hardwood to match the faces. It will be available in 1¾ inch thicknesses in all standard sizes and with a variety of hardwood faces.

The new fireproof door has been tested by Underwriters' Laboratories and approved for a one-hour fire rating in Class B and C interior openings, in vertical shafts, corridors and room partitions. The door also responded satisfactorily to strength and operating tests. **U. S. Plywood Corp., Dept. MH, 55 W. 44th St., New York 18. (Key No. 4029)**

Marlite Polish

Marlite Polish is a new product designed to clean, wax and polish in one operation. It forms a lasting, protective, high-gloss film on smooth wood, plastic or metal surfaces. Non-inflammable and non-explosive, Marlite Polish has a base of Carnauba wax and can be used on furniture, refrigerators, plastic-finished wall and ceiling panels, automobiles, and other smooth surfaces. **Marsh Wall Products, Inc., Dept. MH, Dover, Ohio. (Key No. 4030)**

Launderable Sweeping Mop

The new Fuller launderable sweeping mop fits over a heavy rod supporting frame and is fastened on with a zipper. This speeds assembling and removing the mop from the frame and eliminates parts which might pull off. It is designed to sweep and dust large floor areas and serves both as a floor brush and as a dusting mop. The mop head is easily removed and fully washable. The 4-ply cotton yarn has long-trim and the canvas backing is Sanforized. The mop has a hardwood handle with long upper clamp and is available in 12, 18,

24, 30, 36, 42 and 48 inch widths. The **Fuller Brush Co., Dept. MH, Hartford 2, Conn. (Key No. 4031)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 264

Kaylo Insulation

A new fireproof insulating material is now going into manufacture under the name Kaylo Insulation. A cellular compound of inorganic materials, Kaylo combines light weight with structural strength. It will be manufactured in two weights or densities, 20 pounds and 11 pounds per cubic foot. The heavier density, more than 80 per cent air cells, is designed for use where both structural strength and insulation value are needed, as in fireproof doors, fireproof roof tile and other building purposes. The lighter density, more than 90 per cent air cells, is designed for use where resistance to heat flow is the principal requirement, as heat insulating block, pipe covering and similar uses.

Both densities have great strength despite their light weight and the product can be drilled, sawed and nailed. **American Structural Products Co., Dept. MH, Ohio Bldg., Toledo 1, Ohio. (Key No. 4032)**

Trumatic Folder

The new Trumatic laundry folder is designed as a companion unit for all 120 inch American flatwork ironers. Only one finish fold operator is needed with this machine which has an estimated capacity of five to six hundred sheets per hour. It will handle pieces of all sizes, from 30 to 108 inches in length, without adjustment as pieces are automatically and independently measured for folding. The folder is driven directly by the ironer to which it is attached and can keep pace with regular ironer speed when attended by only one operator. **The American Laundry Machinery Co., Dept. MH, Cincinnati 12, Ohio. (Key No. 4033)**

Non-Toxic Disinfectant

Rodalon 10 per cent is a new germicidal and bacteriostatic liquid antiseptic with a phenol coefficient of 40 at 20 degrees C. It is non-poisonous and non-irritating to tissue and does not stain.

Rodalon is designed for sanitizing surgical equipment and utensils of all types, general disinfecting of floors, walls, furniture, mops and other equipment, and as a general disinfectant, germicide and deodorant wherever bactericidal control is indicated. **Fairfield Laboratories, Inc., Dept. MH, Plainfield, N. J. (Key No. 4034)**

Fresh'nd-Aire Humidifier

A small, compact room humidifier has been announced by Fresh'nd-Aire. A fan draws the air in past the grille work and through the filter, over which there is a constant flow of water. The filtered, washed air is blown gently out of the top of the humidifier. The water reservoir has a capacity of 3 gallons and is easily filled from the side. The unit has Underwriter's Laboratories approval and operates on 60 cycle, 115 volt, A.C. It is finished in crackle-brown on sheet steel and weighs 15 pounds. **The Fresh'nd-Aire Co., Dept. MH, 221 N. La Salle St., Chicago 1. (Key No. 4035)**

Lifetime Tableware

Lifetime tableware, as its name implies, is designed to be practically indestructible. Molded from Melmac, an odorless, tasteless, nontoxic plastic, Lifetime Ware does not chip, crack or craze. It is not affected by food acids or washing compounds and may be boiled for sterilization.

The new ware is carefully molded, is functional and modern in design and has a fine luster. It is available in two attractive colors, Caribbean Blue and Bermuda Coral, and should be of particular interest because of its indestructibility as well as its fine appearance. Institutions caring for mental patients might find it an answer to some of their problems. Lifetime Ware is manufactured by Watertown Mfg. Co., Watertown, Conn., and distributed by **George E. Weigl & Co., Dept. MH, 230 Fifth Ave., New York 1. (Key No. 4036)**

Matched Electric Cooking Appliances

A new line of matched counter electric cooking appliances has been developed to provide maximum cooked food production in a minimum amount of space. There are five appliances available in the set which can be combined in any arrangement or number to fit individual requirements. They are nickel-chromium, automatic units consisting of fry kettle, griddle, grill-griddle, waffle baker and hotplate.

A specially developed banking strip for combining the units in any sequence desired produces a solid bank of food service units while eliminating crevices between appliances that otherwise would cause cleaning problems. Individual signal lights in the front of each appliance indicate when the current is on. Heat controls on all appliances are recessed to prevent accidental operation.

The units may be permanently installed with conduit or can be set up for cord and plug connections. If just one of each of the units is joined with the banking strip, the complete counter kitchen extends 7½ feet from end to end. **Hotpoint, Inc., Dept. MH, 5600 W. Taylor St., Chicago 44. (Key No. 4037)**

Faucet Handle Replacement

A new type faucet handle has been designed to serve as replacement on all standard sink, bath and lavatory fixtures. When handles slip or become stained, cracked or lost, the new Nation-Wide handle can be attached and thus save replacing the entire fixture. It is designed to fit all diameter valve stems, either square or spline shank. It is made of chrome plated brass in both beaver-tale and cross handle types. **Sturgis Plating & Mfg. Co., Dept. MH, Sturgis, Mich. (Key No. 4038)**

Drum Pump

A new drum pump, which utilizes the diaphragm principle, has recently been announced for use where liquids such as alcohol, soap, fuel oil and other supplies are purchased in drums. It requires no priming, has no leather or rotating parts to wear out, and is designed for long, trouble free service.

The pump screws directly into the drum and pumps approximately 15 gallons per minute. A lift of the handle allows liquids to drain into the drum, thus eliminating waste, and an automatic seal prevents evaporation. **Scientific Equipment Co., Dept. MH, 27th and Huntingdon Sts., Philadelphia 32, Pa. (Key No. 4039)**

Velsicol Insect Toxicant

Velsicol 1068 Insect Toxicant is a chlorinated hydrocarbon which is completely soluble in the usual organic solvents and completely miscible with deodorized kerosene. It is highly effective as an insecticide, in the recommended dilutions, for ants, flies, roaches, silverfish, bedbugs and other pests. When used as directed in an insecticidal base oil for the control of crawling insects, an active residual toxicity is said to prevent reinfestation of treated areas for a period of at least two months. **Velsicol Corp., Dept. MH, 120 E. Pearson St., Chicago 11. (Key No. 4040)**

Plastic Mesh Window Shades

The new Celanese Plastic Mesh Vimlite window shades offer the protection of ordinary window shades while letting light into the room. They are cheerful in appearance and effective in screening against glaring light. The new shades are easy to clean because the Vimlite surface is washable. The material will not support fire or combustion and the plastic weave and plastic film coating are long wearing and durable. **Plastishade, Dept. MH, Yonkers, N.Y. (Key No. 4041)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 264

Plastic Expanding Screw Anchors

The new Sandscott plastic expanding screw anchors are designed for tremendous holding power, for simplicity in the anchoring of screws and to reduce cost. The overlapping internal and external slits give "concertina" expansion for dependable holding in any material. They can be used in any type of material with standard wood and lag screws. The anchors are resistant to water, moisture, weather and acids, have high impact strength, are simple to use without any special tools and are inexpensive. They are available in seven sizes and can be easily cut to any length required. **Holub Industries, Inc., Dept. MH, Sycamore, Ill. (Key No. 4042)**

Dishwashing Compound

Oakite Composition No. 66 is especially designed for use in automatic dishwashing and glasswashing machines. It is readily and completely soluble in water at normal temperature and has excellent wetting-out and free-rinsing properties, thus assuring film-free dishes and sparkling glasses. The compound also minimizes hard water scale build-up in washing equipment, thus reducing maintenance problems.

When used as directed, Oakite Composition No. 66 is said to remove lipstick deposits, vegetable and animal fats, milk, coffee stains and other food residues quickly and easily. **Oakite Products, Inc., Dept. MH, 157 Thames St., New York 6. (Key No. 4043)**

Improved Ivory Soap

The miniature Ivory Soap packaged for institutional use has been changed in shape and process to produce a more modern bar providing creamy lather more quickly than the present Ivory bar. The standard wrapper has also been redesigned with an attractive blue and white scalloped pattern.

The new miniature Ivory is available in five sizes, from ½ ounce to 3 ounces. The soap may be purchased unwrapped, with the newly designed standard wrapper or with a specially designed, individualized wrapper. **The Procter & Gamble Co., Dept. MH, Cincinnati 1, Ohio. (Key No. 4044)**

Anatomical Charts

Two new series of anatomical charts for nurse training classes and other teaching, developed by Rudolf Schick, cover the lymphatic system and the endocrine glands. Chart 26, the lymphatic system, covers all vessels, structures and nodes and is a full-colored, large size wall chart mounted on linen with wooden rollers at top and bottom. The chart is edited by Nich. M. Alter, M. D.

There are five charts in the set on endocrine glands, edited by Max A. Goldzieher, M.D., endocrinologist, with a special textbook for studying the charts. The latter are also mounted on linen and wooden rollers. **Rudolf Schick Publishing Co., Dept. MH, 700 Riverside Drive, New York 31. (Key No. 4045)**

Radiant Heating With Baseboard Panels

The new Baseboard Radiant Panels developed by American-Standard fit snugly against the wall when installed or can be partially recessed, saving additional floor space. Available in two models, a radiant panel, Type "R," and radiant-convector panel, Type "RC," this heating panel can be installed along one or more sides of a room in place of the wood baseboard.

The panels are 8 inches high, 2 inches thick and made in two lengths, 12 and 24 inches. Panels are constructed with a cast-in supporting lug on either left or right end and a center section which is available without end support. Special valve enclosures and matching corner covers are furnished so that all piping and valves are readily accessible.

Baseboard Radiant Panels are made of smooth finish cast iron and can be painted to match surrounding walls or woodwork. The design is adapted to the addition of regular wood molding at top and bottom of the radiant panel and at top of the radiant-convector panel. **American Radiator & Standard Sanitary Corp., Dept. MH, Pittsburgh 30, Pa. (Key No. 4046)**

Decorod Drapery Fixture

A new device for quickly hanging draperies has been announced. Known as the Decorod, this fixture is a combination drapery form and arm bracket on which straight, flat-hemmed drapery material is quickly pleated in a matter of minutes. The drapery material is secured with common pins to five tubular forms on the fixture which is made of light steel, painted with rustproof aluminum paint. Attractively pleated draperies result.

The Decorod is well constructed and is designed to fit any window. The adjustable slots make it possible to place the draperies over the windows or extend them to the side. The fixture swings out easily when access to the window is desired. It is easily installed and makes changing draperies for laundering or cleaning a simple process. **Bin-Hay Corp., Dept. MH, 45 Exchange St., Rochester 4, N. Y. (Key No. 4047)**

Fibrin Film

Fibrin Film is a uniformly thin, smooth, sheet-like material made entirely of the coagulating elements of human blood which may be left in the body without causing inflammation. For use, Fibrin Film is soaked in sterile saline solution when it becomes elastic, closely resembling a moist tissue membrane. It has been used in brain surgery, plastic surgery and as a dressing for burns. **Cutter Laboratories, Dept. MH, Berkeley 1, Calif. (Key No. 4048)**

Vycom B

A new high potency vitamin B complex preparation for oral administration in tablet form has been announced under the name Vycom B. It is supplied in bottles of 100 and 500 and in quantities of 1000. **Bristol Laboratories Inc., Dept. MH, Syracuse, N. Y. (Key No. 4049)**

Syrup Sedulon

Syrup Sedulon is described as a new, non-narcotic cough syrup recommended for severe cough, particularly at night. Sedulon, providing a mild sedative action, is a new drug developed by the Roche Research Laboratories and is combined with an effective cough syrup having a pleasing taste, for treatment of both child and adult patients. **Hoffmann-La Roche, Inc., Dept. MH, Nutley, N. J. (Key No. 4050)**

Amethone and Nembutal

A new synthetic compound, Amethone, having an antispasmodic action on smooth muscle in many organs, is combined with Nembutal to prolong the antispasmodic effect and mitigate certain undesired side-effects. The combined medication is provided in capsule form, 50 mg. Amethone hydrochloride and 15 mg. Nembutal to each capsule, in bottles of 100. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 4051)**

Perabeta Capsules

Perabeta Capsules offer a well-balanced formula of B complex vitamins with ascorbic acid. They are designed for the treatment of subclinical deficiencies of vitamins B and C and for supportive treatment during pregnancy and lactation, surgery and other conditions where vitamin supplements are indicated. They are supplied in bottles of 100 and 500 capsules. **Sharp & Dohme Inc., Dept. MH, Philadelphia 1, Pa. (Key No. 4052)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 264

Product Literature

• A 12 page booklet has been issued by Otis Elevator Co., 260 Eleventh Ave., New York 1, describing its free **Vertical Transportation Engineering and Planning Service.** A study of the requirements for vertical transportation equipment, passenger and freight elevators, Escalators and dumbwaiters, for any building, new or old and regardless of size, will be made by Otis engineers without obligation, according to information in **Booklet B-677. (Key No. 4053)**

• Detailed information on **Model 1-A and Model No. 2 Jackson Dishwashers** is given in two new folders issued by Jackson Dishwasher Co., 3703 E. 93rd St., Cleveland 55, Ohio. The machines are fully described with diagrammatic illustrations of their operations. Model No. 2 is designed to meet the needs of institutions feeding large numbers while Model 1-A is designed for those with a smaller load. **(Key No. 4054)**

• **"Noise Reduction"** for hospitals with repaintable Gold Bond Acoustifibre is described in a folder issued by National Gypsum Co., Buffalo 2, N. Y. Quick facts about this product, description, sound absorption data and illustrations of its use are included. **(Key No. 4055)**

• **"Sound . . . A Modern Control System"** is the title of a new booklet issued by Executone, Inc., 415 Lexington Ave., New York 17. The complete line of voice-paging and music systems manufactured by this company is described, together with information on the value of these systems in quickly locating personnel, relieving switchboard congestion, broadcasting general announcements or programs and other helpful data. **(Key No. 4056)**

• A new folder has been issued giving detailed information on **"The '400' Series, National Heat Extractor, Hand Fired, Oil Fired, Stoker Fired."** Designed for dependable heating of institutions, this unit is described by diagrammatic drawings and text. The material was prepared by the National Radiator Co., Johnstown, Pa. Also available are folders on the "100," "200," and "300" series heaters which are designed for smaller institutions and homes. **(Key No. 4057)**

• **"Facing Tile, Structural, Glazed and Unglazed,"** is covered in Catalog 48C issued by the Facing Tile Institute affiliated with Structural Clay Products Institute, Washington 6, D. C. The 36 page book gives factual information on facing tile, on the Facing Tile Institute and has many pages of drawings showing the types, shapes, sizes and uses of facing tile. **(Key No. 4058)**

• The new leaflet on **"Terrazzo"** issued by the National Terrazzo & Mosaic Association, Inc., 1420 New York Ave. N. W., Washington 5, D. C., contains shortform specifications, advantages of terrazzo for floors, bases and wainscots, diagrammatic drawings of terrazzo uses, information on what terrazzo is and illustrations of its use in operating rooms, corridors and lobbies, for wainscot and walls and other uses. **(Key No. 4059)**

• **Information on L.K.R.,** the waterproofing and rust prevention chemical for metal, cement, brick, stone, cinder blocks and wood, is given in a folder and a bulletin issued by L.K.R. Chemical Products Corp., 3105 Park Ave., Detroit 1, Mich. The history of this product, which is applied by brushing to condition walls, floors, foundations and other parts of the building against water and rust, is outlined in the bulletin and full data on its uses are included in the folder. **(Key No. 4060)**

• Information and data necessary for the proper selection of air diffusers is contained in the new catalog and engineering data book on **"Kno-Draft Adjustable Air Diffusers"** issued by the W. B. Connor Engineering Corp., 114 E. 32nd St., New York 16. Known as Bulletin K-20, the new handbook gives full catalog data on the several Kno-Draft Diffuser types and accessories as well as much information of a general nature on the subject of air diffusion, all the information being presented simply and graphically. **(Key No. 4061)**

• A simple method of evacuating patients and personnel as well as all other occupants from a burning building is discussed in a folder issued by the Eastman Evacuator Co., 2902 Stott Bldg., Detroit 26, Mich. The folder describes the **Eastman Evacuator,** a long, canvas chute resembling a gigantic playground slide, down which victims can slide comfortably and quickly when necessary. The device can be permanently installed or quickly attached. The two models, the Ground Ladder and the Aerial-Ladder, are designed for heights up to 55 feet in the first instance and up to 94 feet for the Aerial-Ladder. **(Key No. 4062)**

• All of the models in the line of intercommunication systems developed by the **Talk-A-Phone Co.,** 1512 S. Pulaski Rd., Chicago 23, are illustrated and described in a 12 page catalog recently issued by this company. The low cost standard system which provides standard master cabinets with matched sub-stations and incorporates the "Silent Feature" wherein noises at the sub-stations are cut out even though the sub-stations can originate calls, is fully described. **(Key No. 4063)**

• A scientific treatise on the mechanics of true surgical lighting has been issued by the American Sterilizer Co., Erie, Pa., under the title **"The American Surgical Lighting Technic."** The material contained in the booklet has been correlated over a matter of several years and has been prepared in collaboration with professional and technical workers throughout the field. The various surgical positions are illustrated, complete with models, indicating the proper lighting for each. Interesting photographs of small figures placed in a miniature surgery in relation to patient and equipment are used to bring out specific points. In addition to the surgical positions, general information is included on choice of light intensity, color control, dual control, heat dissipation, head end control, maintenance, shadow reduction and vertical height adjustment. The 32 page book might well serve as a text in teaching nurses and interns surgical lighting procedures and will prove of value as a reference in every hospital surgery. **(Key No. 4064)**

• Duriron acidproof sinks, sink strainers, traps and sanitary pipe and fittings are described and their uses illustrated in a 12 page manual—**Bulletin 703**—recently issued by The Duriron Co., Inc., Dayton 1, Ohio. The manual contains data on the composition of Duriron, its corrosion resistance qualities, use in chemistry laboratories, proper installation, complete check list of uses and specification requirements. **(Key No. 4065)**

• Mouth-watering color photographs indicate the results to be obtained with the **"New Recipes for Mass Baking"** offered in a booklet issued by the Doughnut Corporation of America, 393 Seventh Ave., New York 1. Information on the various Downyflake Baking Mixes and recipes for many types of baked goods which can be made with them should prove of interest to those concerned with feeding problems. **(Key No. 4066)**

• **"The Residual Insect Toxicant, Chlordane,"** is the title of a leaflet issued by Julius Hyman & Co., Denver, Colo., describing this product which kills insects by direct contact, by ingestion and by exposure to vapor. Physical characteristics, uses, toxicity and availability of Chlordane are some of the subjects covered. **(Key No. 4067)**

• The ADSCO Flow Meter of the orifice type for indicating, recording and integrating the flow of steam, gas and air is described in a new 12 page illustrated **Bulletin No. 35-83A** issued by American District Steam Co., North Tonawanda, N. Y. Details of construction, information on orifice plates and other helpful data are included. **(Key No. 4068)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 264

• Detailed information on **"Propylthiouracil for the Treatment of Hyperthyroidism"** is given in a booklet issued by Eli Lilly & Co., Indianapolis 6, Ind. A complete bibliography on the subject is included. **(Key No. 4069)**

• A four page catalog in full color has been published by the Danbury Rubber Co., Inc., Danbury, Conn., on **"Danbury Rubber Tile."** Twenty-three of the 27 Danbury tile colors are illustrated as well as 15 different floor designs in actual color, including several designs submitted by architects. **(Key No. 4070)**

• **"Active Immunization Against Pneumococcal Pneumonia"** is the title of a brochure prepared by E. R. Squibb & Sons, 745 Fifth Ave., New York 22. The history of the development and use of this immunization method and a complete bibliography on the subject complete the booklet. **(Key No. 4071)**

• The full line of **National Cash Registers,** including the most recent developments, is illustrated and described in a folder recently issued by the National Cash Register Co., Dayton, Ohio. **(Key No. 4072)**

• **"Available Now, a New Service for Microfilming All Business Records"** is the title of a leaflet issued by the Microfilm Division of Bell & Howell, 221 N. La Salle St., Chicago 1. Detailed information on this service and its advantages in saving of time and storage space are discussed. **(Key No. 4073)**

• Information on **Fabrit,** the mending material which repairs minor tears quickly and economically without sewing, is given in a leaflet prepared by Textileather Corporation and distributed by Madison Products Co., 3005 Detroit Ave., Toledo 10, Ohio. **(Key No. 4074)**

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Book Announcements

Appleton-Century-Crofts, Inc., 35 W. 32nd St., New York 1, Burstein, Julius, M.D., and Bloom, Nathan, M.D., "Illustrative Electrocardiography," with Slater, Philip, M.D., "Radiology of the Heart," 3rd ed., $6 . . . Cole, Warren H., M.D., F.A.C.S., and Elman, Robert, M.D., F.A.C.S., "Textbooks of General Surgery," 5th ed., 1200 pp., $11. **(Key No. 4075)**

The Blakiston Company, 1012 Walnut St., Philadelphia 5, Pa., Lillie, R.D., A.B., M.D., "Histopathologic Technic," 300 pp., $4.75 . . . Stitt, Clough and Branham, "Practical Bacteriology, Hematology, Parasitology," 10th ed., $10. **(Key No. 4076)**

W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa., Bower, Albert G., A.B., M.S., M.D., F.A.C.P., and Pilant, Edith B., R.N., "Communicable Diseases for Nurses," 6th ed., 657 pp., $4 . . . King, Barry Griffith, Ph.D., and Roser, Helen Maria, B.A., M.A., R.N., "Anatomy and Physiology Laboratory Manual and Study Guide," 3rd ed., 267 pp., $3 . . . Muller, Gulli Lindh, M.D., and Dawes, Dorothy E., R.N., M.A., "Introduction to Medical Science," 2nd ed., 580 pp., $4. **(Key No. 4077)**

Suppliers' Plant News

General Electric X-Ray Corp. announces the removal of its offices from 175 W. Jackson Blvd., Chicago 4, to the new plant at 4855 W. McGeoch Ave., Milwaukee 14, Wis. **(Key No. 4078)**

Sarco Company, Inc., manufacturers of steam specialties, are now located in the Empire State Bldg., New York 1, having moved their main offices from 475 Fifth Ave., New York. **(Key No. 4079)**

John Sexton & Company, 500 Orleans St., Chicago 90, has been appointed national distributor of Pinesbridge Farm Smoked Turkeys. This flavorful product is now available in inexpensive tins for institutional use. **(Key No. 4080)**

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